STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

DEPARTMENT OF FINANCE AND ADMINISTRATION
STATE, LOCAL EDUCATION, AND LOCAL GOVERNMENT INSURANCE COMMITTEES
STATE BUILDING COMMISSION
STATE CAPITOL COMMISSION

Performance Audit Report

December 2015

Justin P. Wilson, Comptroller

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December 11, 2015

The Honorable Ron Ramsey
Speaker of the Senate
The Honorable Beth Harwell
Speaker of the House of Representatives
The Honorable Mike Bell, Chair
Senate Committee on Government Operations
The Honorable Jeremy Faison, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
The Honorable Larry Martin, Commissioner

Ladies and Gentlemen:

Transmitted herewith is the performance audit of the Department of Finance and Administration, State Building Commission, State Capitol Commission, and State, Local Education, and Local Government Insurance Committees. This audit was conducted pursuant to the requirements of Section 4-29-111, *Tennessee Code Annotated*, the Tennessee Governmental Entity Review Law.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the Department of Finance and Administration, State Building Commission, State Capitol Commission, and State, Local Education, and Local Government Insurance Committees should be continued, restructured, or terminated.

Sincerely,

Deborah V. Loveless

Deborah V. Loveless, CPA
Director

15014

State of Tennessee

Audit Highlights

Comptroller of the Treasury Division of State Audit

Performance Audit
Department of Finance and Administration
State, Local Education, and Local Government Insurance Committees
State Building Commission
State Capitol Commission
December 2015

Because Benefits Administration staff did not adequately monitor and verify Lifestyle Management coaching selections, members could have been improperly enrolled in the LM12 coaching program and the state may have unnecessarily paid for their participation
Benefits Administration was not able to replicate coaching selections or ensure that factors and thresholds were as agreed to and not changed (page 9).

Benefits Administration did not adequately monitor coaching calls to ensure the caller provided the reason for selection to members, calls were structured around members' unique risks, and the caller shared the length of the coaching program
Benefits Administration did not review coaching calls on any set schedule, and did not select the calls that they reviewed. Healthways periodically selected and sent a sample of calls to Benefits Administration management for review (page 17).

Benefits Administration's staff did not adequately monitor the contract to determine whether payments were made for participants that did not receive an interactive contact within the times specified by the contract. In addition, BA lacked information on outcome measures and accepted participation reports that did not meet contract requirements or allow for effective monitoring
According to BA's staff, the invoices were only reviewed for duplicate members and billing for multiple programs (page 24).

The Division of Benefits Administration did not ensure that Healthways' subcontractor, Onsite Health Diagnostics, could timely receive, reliably process, and reliably transmit biometric information in accordance with data security and integrity requirements, putting members at risk of losing Partnership Promise status and putting their personal health information at risk

According to the contract, Healthways is to ensure that its electronic data processing and electronic data interchange environments (both hardware and software), data security, and internal controls, and that of any subcontractor, meet all applicable federal and state standards (page 29).

Member satisfaction percentages for the Lifestyle Management and Disease Management programs have not met targeted levels in 2013 and 2014

Target rates on program satisfaction were 85% in the first year of the contract (2013) and have been 90% thereafter (2014-2018). For 2013, Healthways scored 70%, and in 2014, 65%. Healthways paid liquidated damages of $10,000 during 2013 and 2014 for failure to meet the target (page 32).

Some state agencies do not have disaster recovery plans, and agencies with OIR disaster recovery services are not participating in disaster recovery testing, putting sensitive information at risk in the event of a disaster

Two of nine agencies interviewed do not have a disaster recovery plan; agencies with disaster recovery service agreements are not participating in OIR's disaster recovery testing. By declining to participate in disaster recovery testing, agencies are putting sensitive information and critical information systems at risk in the event of a disaster (page 48).

The Office for Information Resources has not always followed its procedure for a biennial review of all Information Systems Council policies

The Office for Information Resources (OIR), serving as staff for the Information Systems Council (ISC), has not complied with its procedure to review and assess each ISC policy biennially. A review of all ISC policies was presented at the October 2011 meeting; the next review was presented at the December 2014 meeting (page 50).

Volunteer Tennessee has not completed its annual subrecipient monitoring plans timely; monitoring is performed after the contract year has ended; and one subrecipient was not monitored within a three-year period

Central Procurement Office (CPO) Policy 2013-007, "Grant Management and Subrecipient Monitoring Policy and Procedures," requires state agencies that award state or federal funds to subrecipients to develop and submit a monitoring plan to the CPO for review and approval annually by October 1. The monitoring plan is a summary of the agency's planned monitoring activities for the current annual monitoring cycle. Volunteer Tennessee did not complete monitoring by the end of the federal fiscal year for all subrecipients selected during either the 2013 or 2014 monitoring years, and is not on track to complete monitoring for all recipients on the monitoring list for the 2014-2015 monitoring year; and one subrecipient in the contract population has not been selected for monitoring on any of the last three plans, as required (page 56).

Volunteer Tennessee has not monitored the 2015 contract for a subrecipient it identified as having solvency concerns; this subrecipient also was allowed to pay questioned costs in installments over a period of time

One subrecipient's 2014 grant year monitoring report observed that the "agency may not be solvent" and, due to the agency's failure to provide requested documentation, questioned costs of $72,778: $17,080 in federal funds and $55,698 in subrecipient's matching funds. This same subrecipient was allowed to repay $4,099 in disallowed costs in monthly installments as the

result of a 2013 monitoring report. In addition to questioned costs from the April 23, 2015 monitoring report, another contract year, 2015, remains to be monitored, creating a potential for further disallowed amounts (page 60).

There is not an adequate formal monitoring system for direct appropriations (repeat finding)

Direct appropriations provide funding to agencies that are not part of state government such as nonprofit organizations or local governments. State departments act as pass-through agencies to record the expenses related to the direct appropriation; recipients file either an accounting of the expenditures or audited financials. Without onsite monitoring to ensure efficient and effective use of the appropriation, state agencies cannot ensure that recipients are using the appropriations for their intended purposes (page 64).

The General Assembly may wish to amend statute to include all out-of-state travel expenditures along with travel and expense reimbursements to improve reporting transparency

Current reporting includes only those expenditures that are reimbursed; travel costs that are direct expenditures are not included. Examples of direct travel expenditures are airfare and meals which are paid for directly by using a state-approved vendor or with the use of a state-issued payment card. While the department may be in compliance with statute, travel expenses incurred without a corresponding reimbursement are not reported, creating a lack of transparency (page 67).

OBSERVATIONS

The audit also discusses the following issues: the complaint tracking process (page 27); the clinical review and the outcome measures report (page 37); the return on investment calculation for the Disease Management and Lifestyle Management programs (page 39); research on wellness programs (page 42); and Volunteer Tennessee's risk assessment (page 62).

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INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of the Department of Finance and Administration, the State Building Commission, the State Capitol Commission, and the State, Local Education, and Local Government Insurance Committees was conducted pursuant to the Tennessee Governmental Entity Review Law, *Tennessee Code Annotated*, Title 4, Chapter 29. Under Section 4-29-237, the department is scheduled to terminate June 30, 2016. Under Section 4-29-238, the State Insurance and Local Government Insurance committees and the State Capitol and State Building commissions are scheduled to terminate June 30, 2017. Under Section 4-29-241, the Local Education Insurance Committee is scheduled to terminate June 30, 2020, but was reviewed with the other two insurance committees because they often meet together. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the agencies and to report to the Joint Government Operations Committee of the General Assembly. The audit is intended to aid the committee in determining whether the department, the commissions, and the committees should be continued, restructured, or terminated.

ORGANIZATION AND STATUTORY RESPONSIBILITIES

Department of Finance and Administration

The Department of Finance and Administration assists the Governor in developing and implementing the State of Tennessee's fiscal and managerial policies. The department's responsibilities involve the coordination of a number of state government activities such as accounting, financial statement preparation, budget preparation and monitoring, and managing state employee health benefits.

The Division of Administration includes the department's fiscal, personnel, billing, and information systems support services as well as the internal audit function and grant programs managed by the Office of Criminal Justice Programs and Volunteer Tennessee.

The Office for Information Resources (OIR) manages the information systems needs of the state, providing technical direction, services, and infrastructure to state agencies. OIR oversees statewide data, voice, and video operations; information systems planning; information

technology training; and security policy, direction, and protection. OIR operates two data centers and serves as staff to the Information Systems Council.

The Division of Accounts is responsible for processing and recording all accounting entries in the state's centralized accounting system, preparing and distributing the state payroll, establishing state accounting policy, and preparing the *Comprehensive Annual Financial Report*.

The Division of Budget prepares and administers the annual budget, a process which entails estimating the revenue and expenditures required to run state government, and monitoring spending and revenue collections of state agencies.

The Division of Benefits Administration manages and administers employee and retiree health insurance programs, the State Employee Wellness Program, and the Employee Assistance Program as directed by the State, Local Education, and Local Government Insurance Committees (which are also included in this audit).

The Division of Enterprise Resource Planning manages Edison, the state's enterprise resource planning system. Edison uses an integrated software package to perform administrative business functions such as financial and accounting, procurement, payroll, benefits, and personnel administration.

The Office of Inspector General is responsible for helping to identify, investigate, and prosecute individuals who commit or attempt to commit fraud and/or abuse involving the TennCare program; recovering money lost due to fraud and abuse; and preventing fraud and abuse from occurring in the future.

The Division of Health Care Finance and Administration includes the Bureau of TennCare, Cover Tennessee, the Strategic Planning and Innovation Group, and the Office of eHealth Initiatives. The Bureau of TennCare is responsible for the administration of Tennessee's Medicaid waiver program. The Strategic Planning and Innovation Group's mission is to determine methods to reward healthcare providers for outcomes such as efficient and quality treatment of medical conditions and individual health maintenance over time. The mission of the Tennessee Office of eHealth Initiatives is to facilitate improvements in healthcare through statewide adoption and use of electronic health records. Cover Tennessee offers health insurance to uninsured individuals in Tennessee. (A Sunset audit of the bureau was published in December 2014.)

The Division of Business Solutions Delivery provides resources, methodologies, and best practices to agencies in support of large, complex information technology implementations.

The Office of the State Architect provides staff support to the State Building Commission, whose responsibility is oversight of all building construction and renovation, demolition, and land and lease transactions for state government.

The Office of General Counsel provides legal support to the department.

State, Local Education, and Local Government Insurance Committees

The State, Local Education, and Local Government Insurance Committees are authorized to manage and administer the insurance programs for state, local education, and local government employees and retirees.

State Building Commission

The State Building Commission oversees construction of all state public buildings. Its responsibility has been expanded to include authority over most acquisition, disposal, improvement, or demolition of real property owned by the state.

State Capitol Commission

The State Capitol Commission is authorized to manage the preservation, restoration, and use of the state capitol and grounds.

REVENUES AND EXPENDITURES

The following are the department's estimated revenues and expenditures for fiscal year ended June 30, 2015, and budgeted revenues and expenditures for fiscal year ended June 30, 2016:

Department of Finance and Administration
Revenues
Estimated FY 2015 and Budgeted FY 2016

	Estimated FY 2015	Budgeted FY 2016
State	$21,254,500	$20,284,900
Federal	$25,233,100	$25,214,500
Other*	$216,754,600	$208,230,800
Total	$263,242,000	$253,730,000

* Other revenue is services to other agencies by the Office for Information Resources, Division of Accounts, and the Division of Budget.

Source: State of Tennessee Budget Fiscal Year 2015-2016 (excludes Bureau of TennCare, which has a separate budget).

Department of Finance and Administration
Expenditures
Estimated FY 2015 and Budgeted FY 2016

	Estimated FY 2015	Budgeted FY 2016
Payroll	$86,440,300	$85,417,100
Operational	$176,801,900	$168,313,100
Total	$263,242,200	$253,730,200

Source: State of Tennessee Budget Fiscal Year 2015-2016 (excludes Bureau of TennCare, which has a separate budget).

As of August 2015, the department has 817 full-time employees.

AUDIT SCOPE

We audited the department's activities for the period October 2011 to August 2015. Our audit scope included a review of internal controls and compliance with laws, regulations, and provisions of contracts or grant agreements that are significant within the context of the audit objectives. Management of the Department of Finance and Administration is responsible for establishing and maintaining effective internal controls and for complying with applicable laws, regulations, and provisions of contracts and grant agreements.

For our sample design, we used nonstatistical audit sampling, which was the most appropriate and cost-effective method for concluding on our audit objectives. Based on our professional judgment, review of authoritative sampling guidance, and careful consideration of underlying statistical concepts, we believe that nonstatistical sampling provides sufficient, appropriate audit evidence to support the conclusions in our report. We present more detailed information about our methodologies in the individual report sections.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

PRIOR AUDIT FINDINGS

Section 8-4-109, *Tennessee Code Annotated*, requires that each state department, agency, or institution report to the Comptroller of the Treasury actions taken to implement audit recommendations. The department filed a report with the Department of Audit in October 2011 following the April 2011 audit report. We conducted a follow-up of all prior audit findings as part of the current audit.

RESOLVED AUDIT FINDINGS

The current audit disclosed that

- the department developed a disaster recovery plan and a Continuity of Operations Plan in response to the finding that it did not have a disaster recovery plan;

- the department has a contracts compliance specialist responsible for monitoring healthcare carriers' corrective action plans; and
- the Office for Information Resources has developed disaster recovery guidance for state agencies, implemented a consulting services preapproval process and a procedure for reviewing Information Systems Council policies, is remediating security risks, and documented rate reviews and analysis for costs models for its services.

REPEATED AUDIT FINDING

The prior audit report included a finding that there is not an adequate formal monitoring system for direct appropriations. This finding is repeated in Finding 10.

OBJECTIVES, METHODOLOGIES, AND CONCLUSIONS

DIVISION OF BENEFITS ADMINISTRATION

Partnership Promise – State Wellness Plan

The State, Local Education, and Local Government Insurance Committees are authorized under *Tennessee Code Annotated* to contract for insurance benefits and related services for state, local education, and local government employees and retirees. (See section on State, Local Education, and Local Government Insurance Committees on page 68.) The committees have designated the department's Division of Benefits Administration to administer these insurance benefits.

Our review of Benefits Administration focused on the state's Partnership Promise Wellness Plan (Partnership) offered to state, local government, and higher education employees. The Partnership provides enrollees, their spouses, and dependents with discounted health insurance premiums and reduced copays if they agree to meet the requirements of the program. Enrollees and spouses in the Partnership are required to complete a Healthways Well-Being Assessment (WBA) every year and a biometric health screening at least bi-annually (annually if required), and participate in coaching if identified.

Beginning July 13, 2012, the state entered into a five-year, $94 million contract with American Healthways Services, LLC, (Healthways) for Healthways to provide "health management and wellness services for the State's Public Sector Plans." The Division of Benefits Administration terminated the prior contract early according to the Executive Director for Benefits Administration, because the prior contract was not performance based. The new contract, the Executive Director said, is oriented on outcomes, not processes. The Executive

Director also stated in a September 2013 hearing of the Fiscal Review Committee that the purpose of the Partnership is to reward those who take personal responsibility for their health.

Objectives and Methodology

The objectives of our review of the state's wellness plan were to determine whether the Division of Benefits Administration properly monitored the contract with Healthways. We reviewed the areas of program enrollment, coaching assessment, monitoring of reports, and program assessment.

For our methodology, we reviewed documentation including the vendor contract and the Request for Proposal (RFP). We interviewed Healthways and Benefits Administration staff, analyzed a sample of recorded coaching calls, reviewed Healthways' business rules for its proprietary algorithm used for identifying members for Lifestyle Management (LM) coaching, analyzed member Well-Being Assessment and Personal Screening Form data, and reviewed Healthways invoices to the State of Tennessee. According to Benefits Administration staff, both the RFP and contract govern the program.

Conclusions

Based on our audit procedures, we determined that Benefits Administration staff did not effectively monitor key areas of the Healthways contract. Specifically, they did not

- obtain specific algorithms, relevant business rules, and complete access to or copies of the state's raw account data;
- verify coaching and voluntary enrollments to ensure the state did not pay for members improperly enrolled into coaching;
- assess the quality of coaching calls and ensure that coaches helped members focus on their identified risks; or
- obtain specific information necessary to reconcile invoices, including month-specific reports on enrollment, graduation, member requirement completion, voluntary enrollments, and expiration of members' active status prior to invoice payment.

We also noted that

- some low-risk Partnership participants were required to participate in coaching,
- we could not verify that members graduated from required coaching,
- Healthways staff were not required to inform members of the specific risks that qualified them, and
- Healthways received and reviewed claims data (medical and pharmacy) for state plan members (Partnership, Standard, and Limited).

Coaching Program Enrollment

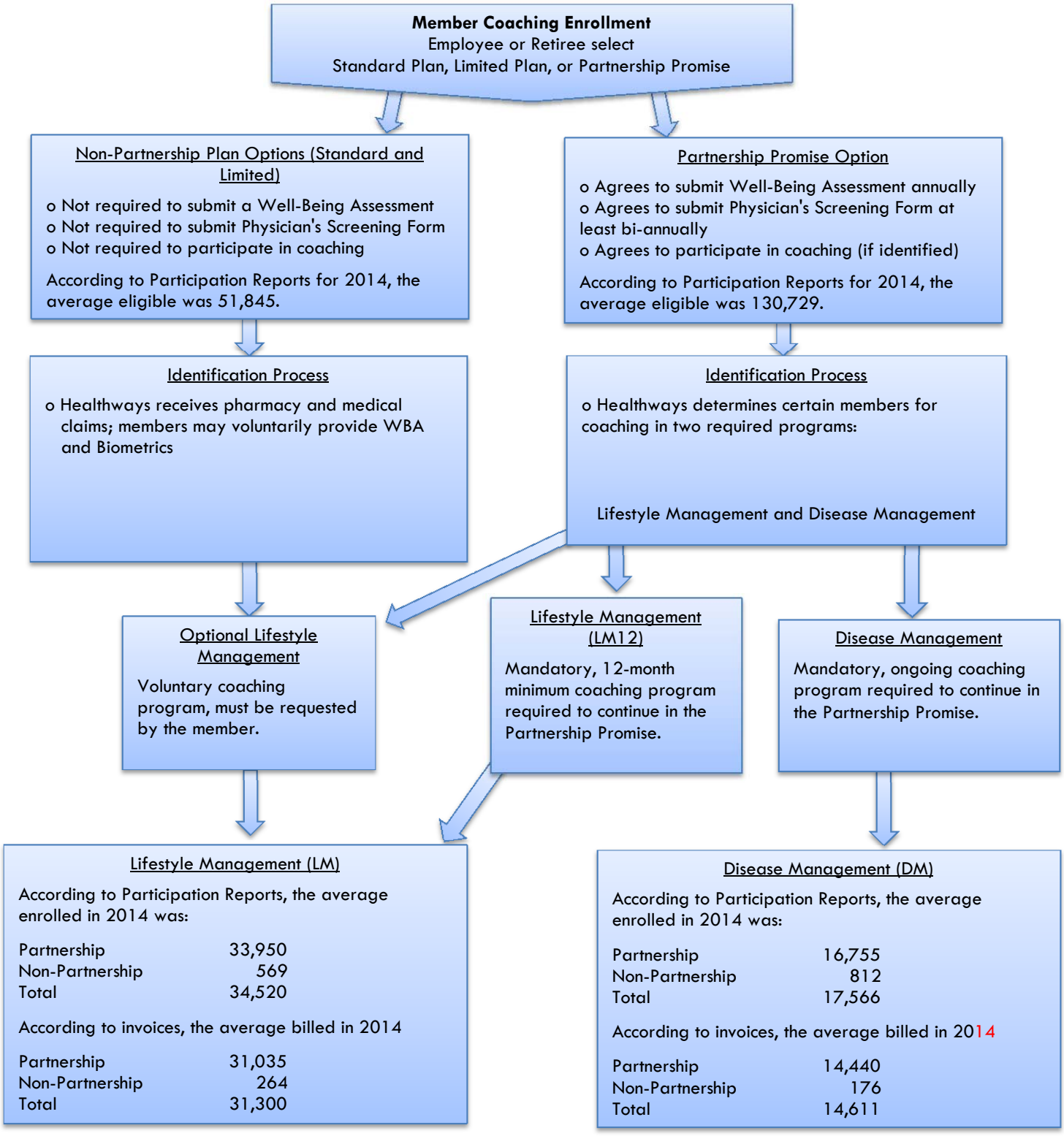
Members of the Partnership insurance option identified with certain health risks or medical conditions receive either mandatory Lifestyle Management twelve-month (LM12) coaching or Disease Management (DM) coaching. (See flowchart on the following page.) Healthways identifies members for coaching through the use of a proprietary risk-based algorithm. Healthways described in its response to the contract RFP,

> Our risk-based coaching algorithm, designed by Healthways' medical and scientific leadership, is designed to identify individuals with significant risk, based on specific biometric values and lifestyle factors, for appropriate level of intervention. . .
>
> Our criteria for enrollment are based upon analysis of medical and pharmacy claims for disease management (DM) and Well-Being Assessment and/or biometric screening data for health coaching.

According to staff of Benefits Administration, Healthways categorizes Partnership members by risk level as "high," "moderate," or "low" through the use of risk factors related to lifestyle. Staff reported, "[T]he presence of multiple moderate risk factors or the presence of one or more high risk factors will qualify someone for telephonic health coaching support. These criteria are used to segment members and identify members most in need of direct health coaching." Members not identified as high or moderate risk, or insured employees in a non-Partnership PPO, can volunteer to participate in coaching; however, Healthways is prohibited by the contract from soliciting these members. The members must initiate communication and request to be enrolled.

The specific criteria for LM12 coaching by Healthways, according to Benefits Administration, is "a combination of three moderate risk factors (e.g., elevated blood pressure, elevated cholesterol, and/or unhealthy eating habits) or one high risk factor (e.g., tobacco use or Body Mass Index of 40 or over)." Once a member is selected for and consents to LM12 coaching, the member is required to participate in the program for at least 12 months, ongoing if re-identified.

Specific criteria for DM coaching include an analysis of medical claims and pharmacy prescription data. Medical diagnosis codes are reported to Healthways and used to identify the presence of a disease. If a member is identified for DM, coaching is ongoing for most programs.



Source: Benefits Administration and Participation reports and invoices January – December 2014

Finding

1. Because Benefits Administration staff did not adequately monitor and verify Lifestyle Management coaching selections, members could have been improperly enrolled in the LM12 coaching program and the state may have unnecessarily paid for their participation

Member Selection for Coaching

Having learned that Benefits Administration did not have the ability to confirm coaching selections, we requested from Healthways the eligibility criteria and risk stratification procedures for the Lifestyle Management (LM) program, including the data and information sources, the criteria for the target population, the factors used in risk stratification, how these factors are weighted, and the threshold for each risk level. Simply put, we asked for what Healthways termed its "algorithm" and participant data used to identify members for coaching so we could replicate and confirm member identifications as high, moderate, and low risk. We chose to review selections for only the LM program because of time constraints and because according to Benefits Administration and Healthways staff LM did not require obtaining medical or pharmacy claims. Healthways first provided us with the business rules for the algorithm used to identify members as "at risk" but after we had identified members in the coaching program who did not meet those requirements, Healthways acknowledged that it used additional information including pharmacy claims.

In January 2015, the State of Tennessee entered into an $840,000 settlement agreement with the previous wellness vendor related to a False Claims Act lawsuit which alleged that the vendor improperly submitted, or caused to be submitted, claims for payment to the state that did not conform to the contract.

As mentioned previously, the RFP details how Healthways uses an algorithm for coaching selection that should target Partnership members that are at "significant risk" as determined by lifestyle factors and biometric data. Members that do not identify as "at risk" are not required to participate and should not be enrolled in the 12-month (LM12) program, though they can voluntarily participate in a coaching program. Benefits Administration staff did not have a copy of the Healthways algorithm, even though the contract requires Healthways to provide it upon Benefits Administration's request. According to the contract, the state has rights to the data and any instruments used regardless of proprietary ownership. (See Appendix 1 for contract information.)

We obtained the business rules for the LM coaching algorithm from Healthways and member assessment data (Well-Being Assessment [WBA] responses and biometric data) on July 21, 2015. We obtained monthly invoices billed by Healthways from January 2013 to May 2015. We also obtained a copy of the WBA questions and, using the supplied business rules, identified the matching questions and corresponding answers that would flag a member as either high (one major) or moderate risk (three moderate). At the time we obtained this information, Benefits Administration and Healthways assured us that the information needed to replicate the coaching selections for the LM program would be in the business rules and data provided for the audit.

The data provided included Well-Being Assessment responses, lab biometric information obtained from the Physicians Screening Form, and self-reported biometric information that members enter into the Healthways system themselves via a website.

We reviewed member assessment data from January through December 2014. We reviewed laboratory data from July 2013 through December 2014. We compared members shown on the invoices as enrolled in the LM12 program to their assessment data and applied the business rules.

As a consequence of not having the algorithm, Benefits Administration was not able to replicate coaching selections, validate member billings on the invoices, or ensure that factors and thresholds were as agreed to and not changed. When asked, Benefits Administration staff could not explain in detail the factors and thresholds that identified members for coaching. We found, based upon a conservative estimate, 3,700 members invoiced as enrolled in the mandatory LM12 program that did not meet the enrollment criteria because they were low-risk individuals, did not possess the required number of risks to qualify for required coaching. This is for 2014 assessment data (January – December 2014); we did not obtain member assessment data for the entire state account database spanning from 2013 to 2015. We estimate that the state paid around $300,000 for these improperly enrolled members. According to Benefits Administration staff, they met with Healthways to discuss the individuals we identified, and Healthways reduced the number to 1,442 members and agreed to return approximately $100,000.

Missing Data

In the database Healthways provided to us, we identified approximately 4,600 invoiced members enrolled in the Partnership-required LM12 program who were missing either WBA responses or biometric lab information. The Partnership Promise program requires both pieces of information for members to stay in the partnership program and receive the reduced premiums. To the contrary, Healthways explained that both pieces of information do not need to be present for the algorithm to be applied. In certain cases, exceptions could be made to relieve a member of the requirements. For example, a member with a needle phobia would not be required to provide lab data. Neither Benefits Administration nor Healthways provided evidence that they excused these members from the requirements, nor did they provide any of the missing member data. Healthways also explained that a member who failed to meet the requirements would be removed from the program the following year but would be allowed to participate in coaching for the present year.

We tested to see if these members were removed from the program the following program year. We compared the identified members (missing either the WBA or Lab Biometric in 2014) to the January and February 2015 invoices. We found roughly 2,500 out of the identified 4,600 members were still invoiced for and were still without one of the program requirements. These members should have been dropped as of January 1, 2015, due to their lack of compliance in the 2014 program year.

Members Moving from LM12 to LM6 and back to LM12

We observed members cycled from the mandatory LM12 program to the voluntary LM6 program and back to the required LM12. According to Benefits Administration and Healthways, members could only transfer from the LM12 program to the LM6 program after they completed their 12-month obligation, mitigated their risks below the required level to be re-identified, and volunteered to continue with coaching for another six months. These members, however, were not graduating from the program after six months of additional coaching; they were re-identified as having risks above the required level. Invoice data we examined shows that approximately 3,600 members transferred from LM12 to LM6, with 1,600 of those returning to LM12.

Benefits Administration Did Not Verify Voluntary Enrollments

Only Partnership members who are identified with moderate/major identified risks are required to participate in the 12 month LM12 coaching program. Healthways management stated that Partnership members who completed their 12-month requirement in coaching and no longer met the threshold to be auto-enrolled into an additional 12-month coaching period, could volunteer to continue with coaching for an additional 6 months. For those in LM12, in the 12th month the coach is supposed to inform the members that they are no longer required to participate in coaching (if risks are mitigated to an appropriate level) and that they may volunteer to continue for an additional six months. This allows members to reconfirm their desire to continue in coaching on a 6-month basis and does not commit them to, or allow for the automatic billing of, 12 months.

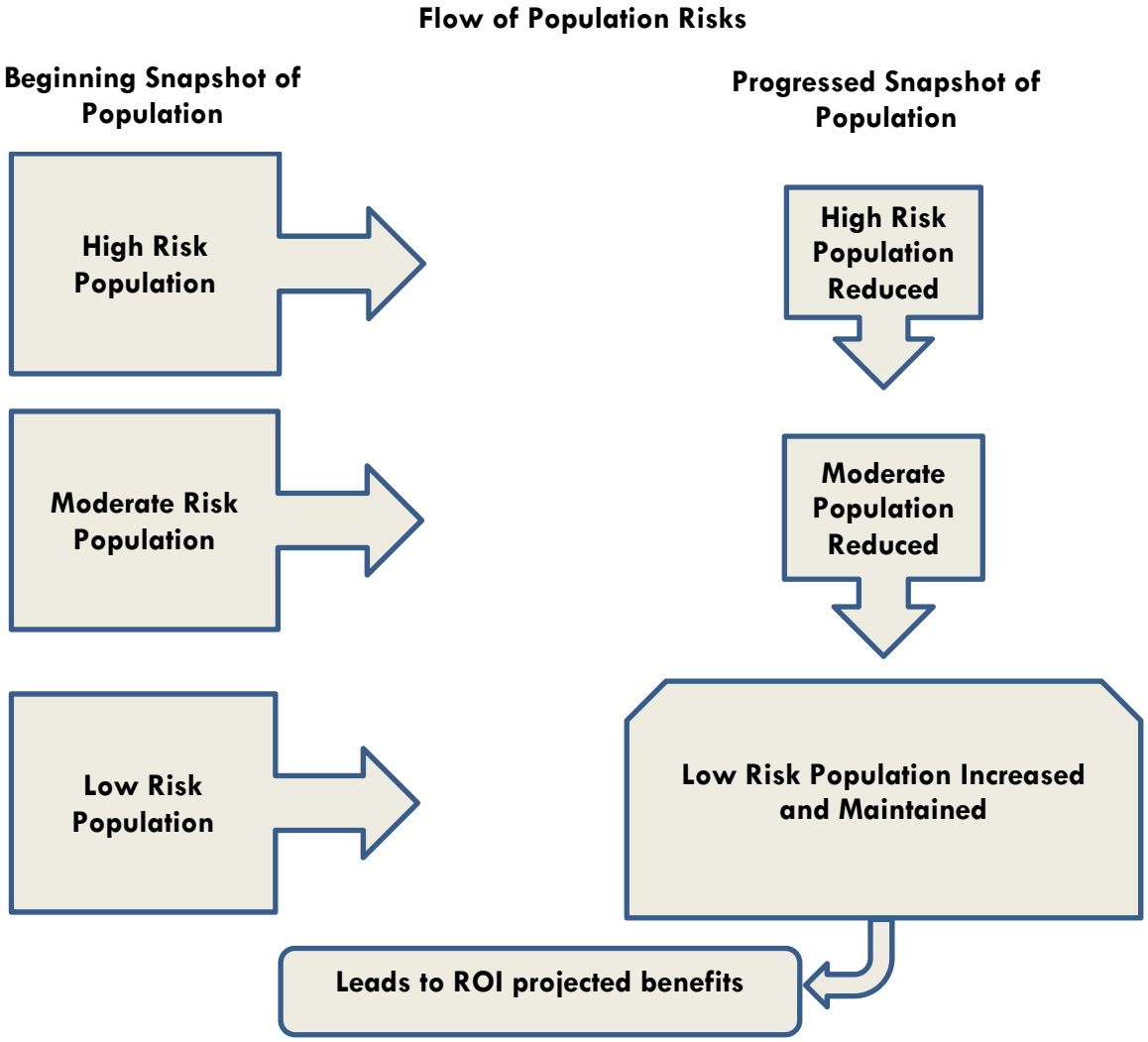
Without verification of voluntary continuation of coaching, Benefits Administration cannot be sure that members truly volunteered or were automatically continued into another required 12 months. As will be discussed further in Finding 3, Benefits Adminstration does not receive reports of members graduating from coaching. Without either graduation reports or verification that members volunteered for further coaching, Benefits Adminstration cannot tell that billing is accurate.

Contract Monitoring Interim Measures

Based on our audit work, Benefits Administration did not track risk mitigation for the Partnership population, which could provide an interim evaluation of the program's effectiveness. To track this information, Benefits Administration would need the algorithm and would need to be able to verify population stratifications through access to members' raw data. Dee Edington, Ph.D., whose work is one of the primary bases of the Healthways program, states that "upper level managers should consider the portion of the population at low risk (0-2 risks) as the metric to measure the success of the health promotion program."[1] Over time, the proportion of the low-risk population should grow as risks in the high and moderate groups are mitigated and members sustain their low-risk status from behaviors gained through participation in the program. Measurement at three-year intervals is suggested. Dr. Edington states that change in costs will follow the change in risks, and programs should have a "success scorecard" that

[1] Dr. Edington is the former director of the University of Michigan Health Management Research Center and the founder of Edington Associates, LLC, a wellness consulting company.

measures the percentage of the population engaged (strategy is for 80-90%) and a low-risk population of 75+%. Benefits Administration should be able to observe changes in the risk populations at the current three-year mark. If mitigated risks are not demonstrated by observable decreases in the high- and moderate-risk populations and an increase in the low-risk population, any positive projected cost benefits reported by the return on investment (ROI) evaluation may be suspect. Changes in the risk populations directly link to benefits shown in the ROI.



Appropriate Payments

According to the wellness contract, in addition to a general fee, Healthways was allowed to bill a program fee for every member enrolled in the coaching program each month, regardless of whether they had contact with a coach. Rates vary by program (LM or DM) and intensity level (high, moderate, low). See Appendix 2 for a chart of the program fees. Benefits Administration routinely paid invoices in full upon receipt without any adjustments.

Recommendation

As contract and program monitor, Benefits Administration should establish more robust monitoring over the Healthways contract including

- sufficiently understanding the application of the selection algorithm to enable effective assessments of Lifestyle Management coaching selections;
- having access to participants' data required to test the algorithm, de-identified to the extent possible;
- comparing the results of its tests of the algorithm to Healthways' billings to ensure only eligible members are enrolled in a program;
- reviewing monthly reports of members added, graduated, and dropped from the program and reconciling with invoices;
- requiring verification of members' intent to voluntarily enroll in continued coaching and testing on a sample basis; and
- considering using acquired algorithms to verify a scorecard of risk mitigation for the Partnership population, stratified by high, moderate, and low risk at appropriate intervals of time, as a tool to monitor interim progress.

The department should also consider other procedures to accomplish improved monitoring.

Management's Comment

- **Benefits Administration should sufficiently understand the application of the selection algorithm to enable effective assessments of Lifestyle Management coaching selections.**

  We concur in part. Benefits Administration (BA) agrees that a review of the algorithm could be useful in providing additional insight into how members are identified for coaching. BA staff recently reviewed the algorithm in detail on-site at Healthways. Our contract has strict and aggressive outcome measures, however, which reflect the aim of the program and for which our contractor is at risk. Because the contractor is at risk for improvements in population health, they owe the state money if they do not achieve the aggressive outcome measures in the contract. Therefore, they have no incentive to enroll individuals who do not have potential for risk reduction. In fact, if they enrolled members in lifestyle management who did not have health risk factors, Healthways would likely not achieve the improvement targets in the contract, which would result in a portion of their fees being returned to the state. BA is measuring and monitoring those outcomes for which the program was created and which are clearly outlined in the contract.

- **Benefits Administration should have access to participants' data required to test the algorithm, de-identified to the extent possible;**

- **Benefits Administration should compare the results of its tests of the algorithm to Healthways' billings to ensure only eligible members are enrolled in a program**

  We do not concur with the two related recommendations above. While BA can gain access to participant data and could test the algorithm we have serious privacy and cost concerns with such an undertaking. We appreciate the recommendation is to "de-identify" the data "to the extent possible" to recognize this concern. However, for the analyses that State Audit recommends it would be very difficult to de-identify the data for this ongoing testing. The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities disclose PHI only to the "minimum necessary" to accomplish the intended purpose. Therefore, this would require outsourcing the sample test work at an estimated cost of $174,000 annually.

  There were 54,781 unique members billed for LM12 in 2014. Using the data provided, State Audit verified that 93.3% of these members were properly enrolled. BA subsequently received additional supporting documentation from Healthways to validate that 97.4% of **members** were properly enrolled. Healthways has agreed to return the fees associated with those improperly enrolled, which total 0.6% of total LM12 invoiced **dollars** in 2014, and is estimated to be $100,000. Implementing an audit at an annual cost of $174,000 to return $100,000 to the state is not a good use of state resources. Therefore, BA does not consider sampling or replicating the algorithm necessary or cost effective.

  Benefits Administration recognizes, however, the importance of having controls to minimize the number of members improperly enrolled in coaching. We will evaluate and identify ways to improve transparency for our members so that they know more about coaching identification and methods for them to follow up should they have concerns or questions.

- **Benefits Administration should review monthly reports of members added, graduated, and dropped from the program and reconcile with invoices**

  We concur. BA believes this could be a useful review. While this information is currently provided to BA for program purposes we will request a separate, ad-hoc report in order to synchronize with the invoices.

- **Benefits Administration should require verification of members' intent to voluntarily enroll in continued coaching and test on a sample basis; and**

  We do not concur. The outcome of this verification work is unlikely to support the cost. In October 2015 only 0.8% of Partnership members were voluntarily enrolled in coaching and only 0.1% of Standard or Limited members were voluntarily enrolled in coaching. Involuntary enrollment has never surfaced as a member concern and verification of members' intent to voluntarily enroll would be administratively difficult. This additional audit work would require outsourcing at an estimated cost of $20,000.

  While we believe this risk is minimal and does not warrant sample testing, Benefits Administration will enhance communication about the voluntary coaching program so that

those who are in non-Partnership programs have a better understanding of their option to enroll in or leave voluntary coaching.

- **Benefits Administration should consider using acquired algorithms to verify a scorecard of risk mitigation for the Partnership population stratified by high, moderate, and low risk at appropriate intervals of time; as a tool to monitor interim progress**

  We concur in part. We agree that risk mitigation is important, which is why risk mitigation will be observed and measured in the LM ROI calculation. BA's scorecard includes the contractual outcome measures focused on improving overall population health. We engaged clinical experts from Aon Hewitt, Truven Health Analytics, and Bailit Consulting to help develop the clinical outcomes measures for this contract. Given the high risk profile of our membership, tracking only risk movement from high to moderate to low could be misleading and is not useful. For example, someone with significant health risks who alleviates one of their risks (a morbidly obese member who stops smoking) is not likely to move to a lower risk profile even though they have made positive health improvements. The Performance Audit notes that according to Dee Eddington, Ph.D. "Measurement at three-year intervals is suggested". BA is following this three-year interval recommendation, as both the LM and DM ROI calculations will be measured after three full program years (2013-2015).

  We will evaluate whether or not this type of interim monitoring would be useful in the future, should the structure of the program change.

Additional Comments for Clarification

Missing Data

Healthways reviewed the list provided by State Audit of members identified as having missing data. All of the approximately 2,500 members fulfilled the Partnership Promise requirement either: (1) by completing a Lab/Biometric and a WBA, or (2) by submitting a 2014 Appeal Form that was approved.

Members Moving from LM12 to LM6 and back to LM12

The identification of members is an ongoing process. New data are collected daily and a single event could trigger someone for coaching or identify a previously unknown risk factor. It is highly likely that new risks develop, particularly as people engage more in their healthcare and begin visiting the doctor regularly. The re-identification could be for a completely new risk factor that was not addressed in previous coaching calls. For example: A member who has a BMI of 40 would automatically be identified with that single, severe risk requiring LM12 coaching. The member lowers his/her BMI after the 12 month coaching period and he/she is reassessed and found to only have two moderate risks (e.g., no exercise and a BMI of 37). The member could voluntarily continue as LM6 (not required) and would be re-evaluated after 6 months. If the re-evaluation proved to identify him/her with three moderate risks (e.g., no exercise, BMI of 37, and high cholesterol) then the LM12 identification would occur and the member would be required to coach.

Coaching Program

The Lifestyle Management 12 (LM12) coaching program is a 12-month program that includes one-on-one telephonic coaching support for each of the following areas: exercise, high cholesterol, hypertension, metabolic syndrome, nutrition, stress management, tobacco use, and weight management. Members were identified for the LM12 coaching program based on their Well-Being Assessment and biometric health screening data. In its Request for Proposals (RFP) packet submitted to the state, Healthways stated that the Well-Being Assessment (WBA) is used to tailor coaching calls to each member's individual unique health needs. Healthways explained that WBA data is also used by clinicians and health coaches as a critical data point for reviewing identified risk factors and establishing health and well-being improvement goals with members.

On the first call, coaches are to review the WBA with the member and identify road blocks to behavioral change. Coaches should be able to identify specifically why a member was selected for coaching. Coaches are supposed to work with members to develop a behavior changing methodology and induce behavioral changes that help reduce identified risks by setting long-term and short-term goals. Members could graduate from the LM12 coaching program if they mitigated or eliminated their identified risks to the point that they no longer met the requirements to be enrolled.

The objectives of our review of the coaching program were to determine whether the coaching programs

- were evaluated by Benefits Administration, and
- provided valuable, beneficial coaching to members based on their identified health risks.

To gain an understanding of the Lifestyle Management and Disease Management coaching programs, we interviewed program staff and agency management and reviewed coaching calls, contract requirements, and member complaints. Due to the complexity of data and time constraints, we focused our review on the Lifestyle Management coaching program.

We selected a random sample of 164 coaching calls from a May 2015 invoice of all active members enrolled in the LM12 coaching program to determine whether or not coaching calls were conducted according to Healthways' contract and RFP agreement with the state.

Based on our audit procedures, we determined that

- Benefits Administration did not sample calls and review them based on coaching practices described in the RFP.
- Healthways staff are not required to tell members the specific health risks that identified them for coaching.
- Coaching call topics did not have to be related to the health risks that identified members for the LM coaching program.

- Benefits Administration did not ensure that the LM coaching program length was clearly communicated to members, or that members were made aware of their completion of program requirements.
- Healthways had 54 health coaches assigned to the state account and had an 18.6% turnover rate for 2015. Based on the May 2015 invoice of 44,935 LM12 members, there were approximately 832 members per coach.

Finding

2. Benefits Administration did not adequately monitor coaching calls to ensure the caller provided the reason for selection to members, calls were structured around members' unique risks, and the caller shared the length of the coaching program

Benefits Administration Did Not Adequately Monitor Coaching Calls

Benefits Administration staff did not review coaching calls on any set schedule, and did not select the calls that they reviewed. Healthways periodically selected and sent a sample of calls to Benefits Administration management for review. At the time of our interview, Benefits Administration staff stated that they reviewed approximately ten calls selected and provided by Healthways during the previous month.

To determine whether members received informative coaching, we randomly selected a sample of 164 members from a May 2015 invoice of 44,935 active members enrolled in the Lifestyle Management (LM12) coaching program.[2] We provided Healthways with the member identification number and the date of latest contact listed on the invoice as the call we wanted them to provide. Healthways was unable to provide 14 of the sampled calls, so we selected an additional random sample of 18 members from the invoice. From our sampled calls, we assessed the content of the calls and found that health coaches and engagement specialists did not state the individual health risks that qualified each member for the LM coaching program, either during the enrollment call or initial coaching call, nor were coaching calls tailored around each member's identified health risks. Coaching calls appeared to be primarily member driven, and coaches structured each call around long-term and short-term goals set by each member. The goals that we observed did not necessarily relate to the health risks that qualified the member for the coaching program. These issues are further discussed in the remainder of this finding. The following is a breakdown of the calls we received from Healthways as a result of our sample. Eight of the sample calls involved members who, when we evaluated their WBA and lab biometric data, did not meet the requirements to be enrolled in the LM12 program.

[2] Although the results should not be projected to the population, we selected a sample which calculates out to an 80% confidence level with a 5% margin of error.

Table 1 Calls by Category	
Call Classification	Number of Calls
Customer Service	2
Engagement Call	11
1st Coaching Call	22
Remaining Coaching	129

Note: Calls were sampled from invoices' Date of Last Contact, which is the date used to qualify coaching active status (see finding 3).

Neither Coaches nor Engagement Specialists Identified Risks

We observed 11 engagement calls in the sample. Engagement specialists made the first contact with members selected for coaching. The specialists were only responsible for gaining members' consent to participate in the program, enrolling them in coaching, and obtaining their preferred contact information. Information presented to members made it seem like they were required to participate in the coaching program solely because they were called to enroll by Healthways, not because they have been identified based on their individual health risks. The Partnership Promise website states, "Partnership PPO members (EMPLOYEES AND COVERED SPOUSES) who are called by Healthways must actively participate in coaching during 2015." During enrollment calls, engagement specialists were not required to tell members why they were identified for coaching. Instead, the script says, "Members who receive this call to enroll in coaching are required to participate to maintain the Partnership PPO from the State of Tennessee in 2015." (See Appendix 3 for the script.)

If members were not notified of their identified risks up front, they had no way of knowing why they were selected or if indeed they had the required number of risks to qualify. Once members consented to participate in the program, they were required to participate for the full twelve months.

According to a script provided by Healthways, engagement specialists were guided to defer specific questions regarding the coaching program to health coaches to answer with the member on the first coaching call. The script specifically says:

- I understand you have questions, but in my role as an Engagement Specialist I request your consent to participate, enroll you in coaching and get your preferred contact information. On your first call with your coach, you will be able to review these questions with them.
- I understand you would prefer not to enroll until you have a better understanding of the coaching program. If I can get the best days and times to call I can schedule a call with a coach and the coach will reach out to you for an overview of coaching and the reason for receiving coaching calls.

In its RFP agreement with the state, Healthways stated that health coaches are to inform the member during enrollment that they are calling to engage them in coaching "due to the specific health risks as identified through the assessment process" and discuss how the program can bring improved health to the member. Coaches were trained to establish rapport with the members based on "their specific health needs" and to "begin addressing actionable health risks and behaviors identified via the WBA and biometric screening." According to Benefits Administration staff, the engagement specialist position did not exist at the time of the RFP. It appears that adding engagement specialists bypasses the RFP requirement that members understand their need for coaching prior to enrolling for coaching.

Of the 11 enrollment calls in our sample, and consistent with the script, none of the engagement specialists mentioned any risks that qualified the member for the coaching program. Our sample of coaching calls included 22 calls that were members' first coaching calls. Only six of these calls (27%) included a review of any WBA or biometric results. According to Healthways, coaches were supposed to review WBA and biometric data with members on the first call and identify any areas of concern. Although we did observe that some coaches reviewed WBA and biometric values with members, in all other calls we did not observe that coaches informed members of the three moderate or one major risk factor that identified them for coaching. When members asked coaches why they were in the coaching program, coaches did not identify all of the specific risks, instead opting for an ambiguous explanation of how each member's WBA and biometric results can be used to identify major and minor risk factors. Examples of these communications are listed below:

> **Example: Call A-** [Health Coach] "We never really have a specific reason why each individual is [selected for coaching] but the main reason people are targeted for coaching is either based on their lab work or if you either have **3 minor risk factors or 1 major risk factor** you are automatically enrolled in coaching."
>
> **Example: Call B-** [Health Coach] "It is based on the Well-Being Assessment that you took as well as the biometric screening, um, that we have in for you, and based on those two there are certain factors that make you eligible for the coaching calls." [Member probes the coach again about why she is in the program, saying her biometrics were fine.] [Health Coach responds] "Yes ma'am, absolutely, and um, based on the, like I said, the Well-Being Assessment, how you answered, they were showing that there could be some improvements, um, **if you are not** getting the amount of recommendations of the fruits and vegetables as one of them as well as exercise, um, and **things like that** are what made you eligible for the coaching calls."

Coaching Calls Were Not Always Structured Around a Member's Identified Health Risks

Benefits Administration did not ensure that Healthways provided members with personalized coaching based on identified factors. Healthways instead chose a more holistic, member-driven approach that focused on broad health concerns. Members can more effectively address their health concerns when they understand how their behaviors affect their health risks.

From the calls in our sample, we observed coaches utilized an approach that focused on topics such as diet, exercise, and stress management. For example:

> **Example: Call C-** [Health Coach] "The wide variety of topics that we usually discuss, there are a couple of popular ones that hit the table here and it's usually like the exercising, the healthy eating, stress management, and weight management are usually the real popular ones, but **we can discuss anything that you feel like discussing on each call.**"

> **Example: Call D-** [Health Coach] "It is up to the members about what is discussed during the coaching calls because it is a **member driven program. . . .** We talk about anything members want to talk about concerning your overall health and well-being and try to see what your main focus is and set small goals with you over the next two months. Lifestyle behaviors that you have control over such as diet, exercise, and stress management. **So for you, what would you say your main priority is**?"

Members were encouraged to choose the topic of each coaching session, and set any number of long-term and short-term health and well-being goals that they could work toward for the next call. However, these individualized goals were not necessarily related to the health risks that qualified the member for the coaching program. In some cases, members did not readily have a goal; however, the coach pushed for a goal, and sometimes suggested one arbitrarily. According to the Transtheoretical Model of behavioral change used by Healthways, coaches are to assess what Stage and Process of change each individual is in. The first stage in the process of behavioral change is consciousness raising, in which individuals learn new information that supports a healthy behavior change. According to the model, the process of change involves an individual's awareness of his or her unhealthy behavioral risks and the consequences of not changing. The model proposes that people can be helped through stages of change by following processes of change that promotes awareness, evaluation of benefits/costs, building self-confidence, and conditioning through the person choosing sustainable healthy behaviors over the unhealthy ones. Interventions should be tailored to the needs of each person at each stage of change. Because the model is based on members being informed of their risks and consequences, coaches should strive to ensure that each member is made aware of his or her identified risks and then help develop personalized coaching plans and goals accordingly.

<u>Benefits Administration and Healthways Did Not Clearly Communicate LM Program Length</u>

Healthways staff explained that the LM12 coaching program is a 12-month program that begins the month members are enrolled and ends around the same time the next year. While enrolled, members' health risks are reassessed every time they complete a coaching call, update their WBA, submit new biometric information, and when Healthways receives insurance claims. Healthways explained that the coaching program is seamless from year to year; as long as Partnership members have at least three moderate health risks or one major health risk, they are automatically enrolled in consecutive 12-month periods until the member mitigates the risks and no longer qualifies for coaching.

Of the 164 calls in our sample, we observed only seven instances (5%) where coaches informed members that the LM12 coaching program was a 12-month program. In addition, the engagement script provided by Healthways notes that engagement specialists only have to inform members that they are required to accept coaching calls for the remainder of the year.

Information on the coaching page of the ParTNers for Health website states that members have to participate in coaching if contacted by Healthways for 2015. However, the Q&A section of the website states that members must continue participating in the coaching program until they are notified differently by their Healthways coach. Benefits Administration did not ensure that the LM coaching program length is clearly communicated to members.

Recommendation

Benefits Administration should monitor Healthways to ensure that members understand their identified risks upon enrollment and again during the first coaching call, and that the coaching calls are structured around those identified risks. Benefits Administration and Healthways should also clearly communicate to members that the LM12 coaching program is a 12-month program and as long as members have at least three moderate health risks or one major health risk, members are automatically enrolled in consecutive 12-month periods until they mitigate their risks and no longer qualify for coaching. Alternatively, members may volunteer to continue in the program.

Management's Comment

We concur in part.

We concur in part with the recommendation "Benefits Administration should monitor Healthways to ensure members understand their identified risks upon enrollment and again during the first coaching call, and that the coaching calls are structured around those identified risks."

State Audit writes that "Benefits Administration did not review coaching calls on any set schedule, and did not even select the calls that they reviewed." We do not agree that the state should review personal and private member conversations about their health and well-being solely for the purpose of auditing the quality of the coaching call, unless we have express permission to do so. This recommendation would undermine the trust and confidentiality that is implied with any provision of health care services. On our website we specifically state "All conversations with your coach are private and are not shared with the health plan or your employer." We conservatively estimate that it would cost $346,000 per year for a third party vendor to do this analysis using a monthly statistically valid sample. We do not consider it the best use of state resources to contract with a third party to conduct an audit of our member's health care conversations for this purpose.

We agree that it is important that members understand their identified risks. We do not agree, however, that this should occur upon enrollment with the engagement specialist, whose role is to set appointments. Benefits Administration will evaluate how to improve communicating to members the coach's responsibility to explain what factors caused a member to identify for coaching. In addition, Benefits Administration will reinforce with Healthways that the coaches are able to describe accurately to members their identified risks, within the framework of the holistic coaching methodology they employ. We will evaluate the cost/benefit of alternative methods of assessing whether the member believes the coach is providing adequate information about their health risks.

We concur with the recommendation "Benefits Administration and Healthways should also clearly communicate to members that the LM12 coaching program is a 12-month program and as long as members have at least three moderate health risks or one major health risk, members are automatically enrolled in consecutive 12-month periods until they mitigate their risks and no longer qualify for coaching. Alternatively, members may volunteer to continue in the program".

BA now clearly communicates the LM 12-month requirement on our website. While communicating the length of the program is not a contractual requirement, this is a programmatic request that BA will make to Healthways. However, it must also be communicated to members that the program is not "one and done" and that they may re-identify later based on the identification of new risk factors or if they have not improved. Members also have a responsibility to understand the program and to engage in understanding their health risks.

Additional Comments for Clarification

Benefits Administration Did Not Adequately Monitor Coaching Calls

We have methods other than phone audit to identify member concerns about coaching calls. Based on member feedback through the monthly program satisfaction survey, the wellness performance survey, agency benefits coordinators' feedback and direct member feedback, we identified and implemented many changes, including those below, in late 2014.

- Some members expected a program design that focused on one specific area of a member's health (e.g. high blood pressure) and did not understand the holistic coaching approach. Healthways addressed these issues by conducting ongoing training for coaching in late 2014 and 2015 specific to our membership. Members should now better understand the coaching requirement, what holistic coaching means and why they are required to participate.
- Healthways implemented several staff changes, including a change in senior level staff directing the call center to better support our members.
- Healthways developed an escalation process should a member feel that they need more information or explanation before agreeing to coach. The member can request that his/her chart be reviewed. Healthways account management will review the member's chart within 5 business days of receipt and contact the member directly to discuss coaching.

Neither Coaches nor Engagement Specialists Identified Risks

Based on comments in the report there seems to be confusion about the role of an engagement specialist versus health coaches. Engagement specialists are call center personnel, not clinical or coaching staff, without the expertise to discuss a member's health risks. Their main goal is to establish a call time with a coach. State Audit stated "It appears that adding engagement specialists bypasses the RFP requirement that members understand their need for coaching." Engagement specialists were added to make better use of the coach's time. Approximately 50% of our members do not keep their committed call appointments. It is a poor use of a clinical coach's time to make call attempts to a member in the hopes that they will be available at that moment to discuss their health status. Instead, the initial outreach is made by the engagement specialist to explain the coaching requirement and to determine preferred call times and phone number. The member has the opportunity to discuss the reasons for coaching during the first call with his/her coach.

Coaching Calls Were Not Always Structured around a Member's Identified Health Risks

We do not agree with State Audit's concerns around holistic coaching. Holistic coaching is the methodology Healthways proposed and focuses on member and coach collaboration in setting goals to mitigate risks. While the coaches will address the risks over time, the coaches may not lead with them. They first allow the participant to tell the coach their goals, barriers, and desires. From there, the coach can collaboratively address how their goals intersect with their areas of opportunity. The risks are discussed, but they are not itemized initially. The approach of addressing all risks on the first call would be disheartening, especially for our population with such high risk factors. Coaches use a combination of education, support, and motivational interviewing for coaching sessions.

Coaches may utilize the WBA and the biometric screening to augment the discussion on the first call; however, a review of all of the WBA and biometric data may not be productive, as some members become defensive. If a member wants to better understand the reason he/she is required to participate in coaching, the coach/clinician should be able to provide the reason. If the coach is unable to explain to the member's satisfaction or the member wants additional information before consenting to enroll, the member can ask that a supervisor review.

Contract Monitoring

Section 12-3-505, *Tennessee Code Annotated,* requires all procuring state governmental entities to create contract monitoring plans. The Department of Finance and Administration's contract management plan includes quality control as a standard for all contracts. The plan states that the department shall inspect and verify the adequacy of the contractor's product. The contract between Benefits Administration and Healthways further stipulates that "the contractor's compensations shall be contingent upon the satisfactory completion of units, milestones, or increments of service. . . ."

The contract monitoring objectives in this audit were to determine

- reporting requirements included in the Healthways contract and if reports were aligned with those requirements;
- how Benefits Administration used reports from Healthways;
- the total liquidated damages collected for 2012, 2013, and 2014 by assessed liquidated damage category; and
- if any auditing work has been conducted by Benefits Administration or if there were plans for auditing in the future.

We obtained and reviewed documentation from Benefits Administration and Healthways, including the contract and reports, and interviewed staff from Benefits Administration and Healthways.

Based on our audit procedures, we determined that

- Benefits Administration did not obtain graduation rates and other information required by the contract and necessary to monitor and manage the contract;
- Benefits Administration's lack of contract monitoring may have led to the state paying for more members in the Partnership Promise Lifestyle Management program than were enrolled;
- the only change to reports provided by Healthways was to the Customer Satisfaction Survey report regarding answers members can select;
- liquidated damages were not due in 2012 because the "go-live" date was January 2013, but liquidated damages were assessed and received for 2013 and 2014;
- Benefits Administration staff reported that the contract does not require auditing Healthways and that there were no plans to conduct an audit;
- Benefits Administration has not obtained or assembled an Outcomes Measurement Report as required; and
- Healthways did not provide complaints resolved over the telephone.

Finding

3. Benefits Administration's staff did not adequately monitor the contract to determine whether payments were made for participants that did not receive an interactive contact within the times specified by the contract. In addition, BA lacked information on outcome measures and accepted participation reports that did not meet contract requirements or allow for effective monitoring

Lack of Monitoring of Active Status Could Lead to Overpayment on Invoices

Benefits Administration did not test for active and non-active member status on invoices prior to payment. Invoices should only include active members, those for whom Healthways

completed and documented a successful interactive call within the specified time period. If a documented contact does not occur within the designated time frame, the contract terms have not been met and the member should not be included in that month's invoice.

According to BA staff, the invoices were only reviewed for duplicate members and billing for multiple programs. Since active members should be paid for, there should not be any non-active members on an invoice. Staff explained that the methodology used for the invoices allowed the vendor to include a member on the monthly invoice on the month when the member's active status ended, without confirming that a successful call occurred in that month.

One option is for Benefits Administration to prorate monthly payments and only pay for part of a month a member is in active status. Using a prorated method, we estimate that for 2013, the state could have saved over $400,000.

Inability to Reconcile Participation Reports to Invoices

According to the contract between the state and Healthways, under reporting requirements, Benefits Administration is to obtain a monthly Program Participation Report. This report is to include

- the number and percent of eligible members (by type of PPO) who are/are not participants (by active and inactive participation) by program (lifestyle management and DM risk level), and condition (e.g., weight management, diabetes);
- the number and percent of eligible members (by type of PPO) that could not be contacted; and
- information on participants who graduated, and summary of co-morbid conditions by condition.

Benefits Administration approved a Healthways-designed monthly participation report, a snapshot of the state membership activity displayed through certain metrics and created between the end of one month and the 13th day of the next. Healthways submitted invoices to Benefits Administration for activity during the previous month.

We reviewed the participation reports and invoices and determined that in addition to the reports not linked in terms of periods of performance, as required in the agency's monitoring plan, there was not enough performance information provided to reconcile the two.

During our review, there were three instances—July 2014 (1,779), August 2014 (885), and November 2014 (153)—where the invoices included more members than were listed as enrolled in the monthly participation report. Benefits Administration staff did not document noticing these discrepancies. According to Healthways, it was possible for an invoice to have more members than the participation report because of members opting out of the program between the end of the month covered by the invoice and the date of the participation report, sometime before the 13th of the next month. Nevertheless, the data suggests that for these three

months, the state may have paid for more members than were enrolled and illustrates the importance of being able to reconcile these documents.

Participation Reports Did Not Include Graduation and Category Information

Contrary to what the contract required, the monthly participation reports did not include the number of graduates for the month and other information. This prevented Benefits Administration from using monthly participation reports to validate corresponding invoices. Benefits Administration was also unable to determine if graduates were included on subsequent invoice statements. According to Healthways, the participation report included graduation information in aggregate, under a section named "Non-participation" in a category called "Coaching Concluded for the Year," which included graduates and members who have completed their coaching calls for the year.

The monthly participation report also does not include the number of new enrollees in the coaching program and does not break down enrollees by high-, moderate-, and low-risk members. This category-specific data is required to track program participation and level of risk mitigation, which would be an interim measure program success. According to Healthways, the participation reports included this information in aggregate rather than specific numbers for each category, but this limited the usefulness of the report as a monitoring tool.

Recommendation

Benefits Administration should validate invoice information to avoid paying for inactive members. Benefits Administration should obtain monthly reports that link performance to compensation and that include detailed information about each program plan, including breakdown by active/inactive, risk levels, and graduation, as stated in the contract. Benefits Administration should use those reports to evaluate program effectiveness and as part of its contract monitoring program.

Management's Comment

We concur in part.

Program Integrity staff compared the contract and RFP language to Healthways billing methodology and determined that Healthways was adhering to the contract terms. BA has now implemented a monthly review process prior to invoice payment that examines whether a member is active during the month according to the contract and RFP terms.

BA will consider State Audit's recommendation to pro rate monthly payments and only pay for the part of a month a member is in active status in future procurements. Under the contract a member is considered active on the monthly invoice if the member is active during any portion of the month. Our current procurement did not outline the billing arrangement suggested by State Audit nor does our current contract permit partial month billing. This may

add administrative complexity and may result in a higher monthly billing rate, thus negating the $400,000 savings State Audit estimates would be achieved through pro-rated monthly payments. However, we will evaluate this and other billing options in a Request for Information (RFI) prior to our next procurement and will consider the cost/benefit of such alternative options.

The participation reports are used for a program wide perspective of membership, while the invoices are a payment mechanism at a member level. The purpose of these two reports is very different. In order to reconcile the invoice, BA will request Healthways to provide an additional report with similar data elements that matches the timing of the invoice. In addition, BA will request that Healthways include the graduation rates to the existing participation reports. We agree that we should monitor program effectiveness but through the measures outlined in the contract, not through the data on these reports.

Additional Comments for Clarification

State Audit references that for three months the invoiced LM enrollees exceeded what was shown on the participation reports for those months. We provided State Audit with 27 months of participation reports and invoices. For these 27 months, there were 24 months where the participation reports showed the number of LM members enrolled **were greater** than the number invoiced. We do not agree that the data for the three months referenced by State Audit suggest that the state paid for more members than enrolled, just as we do not agree that we underpaid Healthways for the 24 months referenced above. We have clarified that the invoice and the participation reports are not synchronized, do not measure the same things and that BA verified that we have correctly paid Healthways according to the contract terms.

State Audit noted that new enrollees were not provided on the monthly Program Participation Report. This information would be useful, and we will work with Healthways to add this element to the above mentioned ad hoc report. It is worth noting that the current report does provide category specific data broken out by risk level. Disease Management includes high, medium and low while Lifestyle Management categories risk by Low Risk and At Risk. There are no high, medium and low risk categories for LM.

Observation

1. Benefits Administration allowed Healthways to use a complaint tracking process that did not include all member complaints

According to its contract with the state, Healthways is to submit quarterly reports to Benefits Administration with information regarding each complaint filed by members. Healthways did not include in its quarterly report information on complaints that were received informally over the phone and resolved over the course of the conversation. In order to have a clear picture of the nature and quantity of each complaint and to assist with efforts to address member satisfaction, Benefits Administration should strive to ensure that all member complaints are tracked and submitted quarterly by Healthways.

Management's Comment

We concur in part. However, this is by our design. The member resolution process builds in the ability for the front-line customer service representative to address any issues or concerns that the member might have. BA reviewed and approved this process. For example, the member could call to file a complaint because of an issue with Well-Being Connect only to discover that the reason for their issue was the use of an incorrect username/password or they had forgotten their username/password. The representative would assist with providing the member's username and/or reset the password. Once the issue was resolved, the member would be asked if they still wish to file the complaint. If the member says no then the complaint is not recorded, however, if the member says yes, then the complaint would be filed and noted on the quarterly report. Logging all member inquiries would over inflate the number of true member complaints.

Tracking of Partnership Promise Requirements

Partnership Promise members are required to complete an annual Well-Being Assessment. Members in coaching must complete a biometric health screening every year while other members must complete the screening every other year. The program provides a Physician Screening Form for members to take to their physician to document the screening, sign, and submit to Onsite Health Diagnostics. OHD subsequently submitted the data electronically to Healthways to be used in risk assessment.

The objectives of our review were to determine the process used by Healthways and its subcontractors to document member completion of program requirements, communicate to members that requirements were met, and determine the number of members and the reasons for changing from the Partnership Promise plan to the standard plan in 2013 and 2014.

We reviewed documentation from Healthways, the Division of Benefits Administration, and the Tennessee State Employee Association. We interviewed the Division of Benefits Administration and Healthways staff.

Based on our audit procedures, we determined that

- biometric screening forms and onsite health screening information were received by Healthways' subcontractor, Onsite Health Diagnostics, which processed the information on the forms into useable electronic data, then transmitted the data to Healthways;
- Benefits Administration could not ensure that member biometric screening data was adequately processed and transmitted to Healthways;
- the most common reason for an appeal of program dismissal was related to the biometric screening form; and
- in 2014, the most frequent reason for sending a transfer letter was the biometric screening form.

Finding

4. The Division of Benefits Administration did not ensure that Healthways' subcontractor, Onsite Health Diagnostics, could timely receive, reliably process, and reliably transmit biometric information in accordance with data security and integrity requirements, putting members at risk of losing Partnership Promise status and putting their personal health information at risk

Lack of Data Security Assessment Report

According to the contract, Healthways is to ensure that its electronic data processing and electronic data interchange environments (both hardware and software), data security, and internal controls, and that of any subcontractor, meet all applicable federal and state standards.

In light of repeated data breaches and problems receiving forms and transmitting biometric data to Healthways, we requested from the division and from Healthways an AICPA (American Institute of Certified Public Accountants) certified report on data security and integrity known as an SSAE16 (Statements on Standards for Attestation Engagements number 16) or SOC 2 (Service Organization Control) report. The SSAE16 or SOC reports, as completed by an independent auditor, verify controls and processes in place for a data center and require a written assertion regarding the design and operating effectiveness of the controls reviewed. A SOC 2 Type 2 report takes the assertion a step further and covers controls relevant to security, availability, processing integrity, confidentiality, and privacy. This report provides assurance that data is complete, accurate, timely, and properly protected.

Benefits Administration informed us that Healthways should have such a report for its subcontractor, Onsite Health Diagnostics (OHD). Despite numerous requests to Benefits Administration and to Healthways to provide the report, it was not provided. Without the report, the division cannot assure members that their personal data is securely stored and reliably processed.

Onsite Health Diagnostics (OHD) Data Breach

According to an August 22, 2014, Benefits Administration memo, between January and April 2014, "an unknown source gained unauthorized access" to an outdated OHD database that was part of a system no longer in use. The information stored in that database contained the names, dates of birth, addresses, email addresses, phone numbers, and gender of 60,582 members in the state's wellness program who had requested the Physician Screening Form. The memo mentioned that OHD became aware of the breach on April 11, 2014, and Healthways notified the state on June 10, 2014. Healthways reported to the division that OHD has a new system and that Healthways was satisfied with the security of the new site.

The OHD data breach was not limited to Tennessee. Problems occurred with another wellness program provider using OHD as a subcontractor at a Virginia-based employer and another at a Missouri-based employer. The Virginia employer reported that the breach included

the same types of data as Tennessee's but also employee encrypted passwords. That company is no longer using OHD.

Difficulty Submitting Biometric Forms

Members of Partnership Promise had difficulties because Healthways did not always receive lab biometric information. We reviewed Tennessee State Employee Association email responses, and responses from a recent Benefits Administration survey that included comments such as having to submit the form multiple times and having to appeal to stay in the Partnership Promise. Members received letters of noncompliance, even after they called and confirmed that OHD received the form. During the audit, we became aware of at least one physician's office that would no longer fax the form to OHD on its patients' behalf because of repeated problems; too many patients received notice the form was not received.

Appeals report information showed the most common reason for an appeal is the biometric screening form. For 2014, a total of 9,440 out of 17,737 appeals (53%) were related to the biometric screening form. The appeals report also shows that those who appeal for Physician Screening Form issues have their appeals overturned 90% of the time. This allows members to remain in the Partnership program; however, having to go through this process is time-consuming and stressful.

Table 2
Partnership PPO Appeals (January-December 2014)

Category	Upheld	Percent	Overturned	Percent	Pending	Total
Biometric Screening	26	8%	284	91%	2	312
Case Management	3	8%	31	78%	6	40
Coaching Participation	**408**	**8%**	**4,527**	**88%**	199	**5,134**
Death in Family			14	100%		14
Medical Leave/Exception			117	100%		117
Member Deceased			1	100%		1
Other	22	12%	161	87%	3	186
Out of Country – Military			6	100%		6
Out of Country - Non-Military			12	100%		12
Physician Screening Form	**843**	**9%**	**8,500**	**90%**	97	**9,440**
Pregnancy	17	3%	479	hang		496
WBA	**348**	**18%**	**1,622**	**82%**	9	**1,979**
Total	1,667	9%	15,754	89%	316	17,737

These values are from Healthways' 2014 monthly appeals reports submitted to Benefits Administration.

According to Healthways, the most frequent reason for sending a transfer letter in 2014 was the biometric screening form, 21,160 out of 31,968 mailed letters (66%).

In a meeting with Healthways, the account manager mentioned that there were fax machine problems with OHD. For the 2015 program year, to remedy the fax problem, OHD

allowed an upload option for submitting the form (in addition to the mail option). Members could upload the completed form to OHD through a designated hyperlink. However, as of July 28, 2015, which is 13 days after the due date of July 15, BA provided information that shows 14,713 of 90,679 members' biometric forms (16%) were not yet received. This is consistent with 2014, when 19,828 of 132,203 members' forms (15%) were not received as of September 22, 2014. Because the percentage of member forms not received is approximately the same, the department should consider what other methods it can use to get the forms turned in. There are other reasons screening forms may not reach Healthways: members may have decided not to have the screening, members may be unaware of the requirement until they receive the transfer letter, and the physician's office may have neglected to send the form.

Recommendation

We recommend that Benefits Administration acquire from Healthways an SOC type 2 data integrity report of Onsite Health Diagnostics (OHD). We further recommend that Benefits Administration take steps necessary to ensure members are able to submit required information efficiently and effectively and that member data is properly processed and secured. If OHD is unable to meet the services and expectations required, Healthways should find a new subcontractor.

Management's Comment

We concur. Healthways has received and provided to Benefits Administration a SOC 2 Type 2 report with an unqualified opinion from Onsite Health Diagnostics. In addition, BA and Healthways have worked very closely to improve the member experience with downloading and submitting the physician screening forms, including a dedicated fax line for State of Tennessee members.

Additional Comments for Clarification

On average 84.5% of members did submit the physician screening form timely and without issue. In reviewing the average completion of a biometric screening requirement for other programs, the completion rates vary between 48% - 60% (2015/2016 Global Staying@Work Survey, United States US EMPLOYEE VIEW; National Business Group on Health, WISCORE® 2012/2013 Results: Measuring the Impact of Wellness on Workforce Health, 2014). That means our completion rates are well above the average for many other programs.

Finding

5. Member satisfaction percentages for the Lifestyle Management and Disease Management programs have not met targeted levels in 2013 and 2014

Healthways conducts a monthly Program Satisfaction Survey. BA staff indicated that there is no annual year-end program satisfaction report and that they did not use monthly reports for trend analysis. For purposes of assessing liquidated damages, the number questions marked satisfied or approval met is divided by the number answered. Not all survey questions are included in this calculation. The Healthways contract outlines the areas in which to collect customer satisfaction information from participants in the Lifestyle Management and Disease Management programs: "overall program services, ease of administration, overall program quality, coaches, usefulness of information, effectiveness of adherence to treatment, assistance in self-management plans, and whether they would recommend the program to others."

Target rates on program satisfaction were 85% in the first year of the contract (2013) and have been 90% thereafter (2014-2018). For 2013, Healthways scored 70%, and in 2014, 65%. Healthways paid liquidated damages of $10,000 during 2013 and 2014 for failure to meet the target. Because the amount of the Healthways contract is more than $94 million over the five years, the penalty for failing to meet the performance guarantee may not be a significant financial concern for Healthways.

Recommendation

Benefits Administration should review performance information and work with Healthways to improve the wellness program until Healthways meets satisfaction targets.

Management's Comment

We concur. BA continues to work closely with Healthways to improve the member experience and perception of the program. Member satisfaction, however, reflects both the requirements of the program as well as member experience with our contractor. BA analyzed thirty-three months of member complaints related to the Lifestyle Management program pulled directly from the monthly satisfaction reports. Of the 395 survey complaints, 315 (80%) of the feedback was specific to the program design, particularly the requirement to coach. Many members simply do not like the requirement to coach, even though they receive lower cost-sharing as a result. Eighty of the comments (20%) were specific to an experience with Healthways coaches, such as trouble connecting with their coach, the coach was not helpful, or the coaches are just reading scripts, etc.

Partnership Program Success

Our objective for this section of the audit was to review the Partnership Promise wellness program and determine if the program successfully met its outcome measures.

To understand the wellness program evaluation, we interviewed Benefits Administration staff, reviewed the wellness program's expected outcomes, and interviewed representatives from Aon Hewitt, the vendor responsible for assisting Benefits Administration in determining the return on investment (ROI) of the wellness program. In addition, we reviewed published research to learn about the impact that wellness programs have on companies and their employees.

We determined that Benefits Administration is in the process of conducting a clinical review of the Partnership Promise, has not obtained an Outcome Measures Report from Healthways, and that Benefits Administration should carefully review the Disease Management (DM) and Lifestyle Management (LM) programs' ROI calculation to ensure that the ratios are calculated correctly and the calculation process is objective. In addition, research indicates that certain aspects of wellness programs have little to no impact on lowering medical costs for employers or on producing a positive return on investment.

Plan for Evaluating Program Success

In 2012, Benefits Administration contracted with Healthways to begin managing the wellness program. In the contract, Benefits Administration requires that Healthways' performance be evaluated using the following outcome measures:

- **Utilization Rates** (Hospitals) – The number of times members receive care in a hospital setting.
- **Clinical Outcomes –** Biometric results collected during physician screenings to evaluate the wellness program population's level of obesity, hyperlipidemia, glucose, blood pressure, and hypertension.
- **Disease Management Program's Return on Investment**- Ratio to determine if the state is earning a positive return from services Healthways provides to individuals in the wellness program's Disease Management Program.
- **Lifestyle Management Program's Return on Investment**- Ratio to determine if the state is earning a positive return from services Healthways provides to individuals in the wellness program's Lifestyle Management Program.

According to the contract, Benefits Administration evaluates each outcome measure using the guidelines in Table 3.

Table 3 Healthways' Outcome Performance Measures	
Performance Measures	**Expected Outcomes**
Utilization Rates (Hospitals)	A reduction of inpatient admissions per 1,000 by a minimum of 5% from baseline in year one as measured by claims
Clinical Outcomes- Biometric Results	i. Obesity -A 5% weight loss for at least 20% of Partnership members with a BMI greater than 30 who are enrolled in a program. ii. Hyperlipidemia- For diabetic members only, improve the percent of program participants meeting LDL target of 100mg/dl by 5% over the 2011 baseline in year one and a minimum of 5% again in year three as compared to year one. iii. Blood Pressure: Improve the percent of program participants meeting blood pressure target by 5% over 2011 baseline in year one and a minimum of 5% again in year three as compared to year one iv. Glucose- reduce the percentage of program participants meeting criteria for pre-diabetes (fasting blood sugar between 100 and 125) by 5% over 2011 baseline in year one and a minimum of 5% again in year three as compared to year one. v. Hypertension- Improve the percent of program participants identified with hypertension who are compliant with their medications by 5% over the baseline in year one. Measured using prescription drug claims to calculate medication possession ratio. Ratio of 80% will define compliance. Rate should improve by 5% in year two, and another 5% in year three.
Disease Management Return on Investment (ROI)	Reduction in per member per year (PMPY) plan costs for DM participants
Lifestyle Management Return on Investment (ROI)	Reduction in per member per year (PMPY) plan costs for LM participants.

Source: Contract between the State of Tennessee and American Healthways Services, LLC (pgs. 54-55).

To determine if Healthways met the expected outcomes for each performance measure, Benefits Administration designed two separate evaluation processes. During the first evaluation process, Benefits Administration analyzes information that includes the utilization rates and clinical outcomes performance measures by using data collected from medical claims and members' biometric information gathered from physicians' offices. The biometric information is provided by Healthways via Truven, the state's data warehouse vendor. For the second evaluation process, Benefits Administration receives assistance from the actuary firm Aon Hewitt to determine the return on investment of expenses paid for services Healthways provided through the Partnership's programs.

Evaluating Outcomes: Utilization Rates (Hospitals) and Clinical Outcomes

At the time of audit fieldwork, Benefits Administration was in the process of creating a methodology to analyze data from 2011 to 2016 and determine whether or not utilization rates and clinical outcomes improved as required in the contract. If the results show that Healthways did not meet the outcome requirements. Healthways will be required to refund a percentage of the contract's program fees and general fees, as shown in Table 4.

Table 4
Fees at Risk: Utilization Rates and Clinical Outcomes

Performance Measures	Year 1 (2013)	Year 2 (2014)	Year 3 (2015)	Year 4 (2016)	Year 5 (2017)
Utilization Rates (Hospitals)	3% of DM Program Fees	3% of DM Program Fees	3% of DM Program Fees	---	---
Clinical Outcomes					
i. Obesity:	---	---	4% of General Fees	---	---
ii. Hyperlipidemia:	4% of General Fees	---	4% of General Fees	---	---
iii. Glucose:	4% of General Fees	---	4% of General Fees	---	---
iii. Blood Pressure:	4% of General Fees	---	4% of General Fees	---	---
iv. Hypertension:	4% of General Fees	4% of General Fees	4% of General Fees	---	---

Source: Contract between the State of Tennessee and American Healthways Services, LLC (pgs. 53-54).

Evaluating Return on Investment (ROI) for the Disease Management and Lifestyle Management Population

Aon Hewitt is the company responsible for calculating the ROI ratios for the DM and LM programs, and expects to release the first ROI report in 2016. The report will determine if the State of Tennessee received a positive return from expenses paid for services Healthways provided to members in the LM and DM programs. Although Benefits Administration will not know the first ROI ratios until 2016, we reviewed Aon Hewitt's methodology to learn how the ROI ratio will be calculated.

Calculating Disease Management ROI

Aon Hewitt will first calculate the per member per year (PMPY) cost amount based on the claims information of individuals in the Partnership Disease Management program. Next, Aon Hewitt will calculate the per member per year expense based on the amount of DM program fees that Benefits Administration paid on each member for the year. Aon Hewitt will divide the

PMPY cost by the PMPY expense to calculate the DM ROI ratio for the year, shown in the following formula:

$$\frac{\text{Disease Management PMPY Costs}}{\text{Disease Management PMPY Expenses}} = \text{Disease Management ROI}$$

Benefits Administration will compare the DM ROI ratio to the ROI ratio in the contract to determine if Healthways met its yearly minimum. If Healthways does not meet the minimum ROI, Healthways will be required to refund a percentage of the DM program fees paid for that year. The ROI ratio minimums for the DM program and the amount of program fees that Healthways will be required to pay back are shown in Table 5.

Table 5
Disease Management Program Minimum ROI and Amount of Fees to Be Refunded if Not Met

Year	Year 1 (2013)	Year 2 (2014)	Year 3 (2015)	Year 4 (2016)	Year 5 (2017)
Minimum ROI Ratio	---	---	1.5 to 1	2.0 to 1	2.5 to 1
Fees at Risk	---	---	97%	100%	100%

Source: Contract between the State of Tennessee and American Healthways Services, LLC; RFP proposal.

Calculating Lifestyle Management ROI

Similar to the DM program, Healthways has a minimum ROI that it must meet for the Lifestyle Management (LM) program from 2013 to 2017. However, instead of using claims data to calculate PMPY costs, Aon Hewitt will use a process initially created by Healthways, but that it later reviewed and modified to determine the PMPY costs.

The calculation of LM costs is primarily based on a 2001 study by Dr. Dee Edington titled "Emerging Research: A View From One Research Center." In the study, a Risk Value Table was created that assigned estimated future health costs to current health risk. For example, if an individual currently has a high cholesterol level, the Risk Values Table will estimate the health costs that the individual will incur in the future as a result of currently having high cholesterol. In contrast, if an individual no longer has a certain health risk, the table assigns a future cost savings to that person. We cannot be sure that Benefits Administration can validate data for mitigated and non-mitigated risks per member in the LM ROI calculation because only Healthways, and not Benefits Administration, has direct access to the complete database of member data (see Finding 1).

Healthways assigns an estimated health cost or health savings number to each participant in the LM coaching program. Aon Hewitt will add the numbers for all participants and divide by the population to calculate average expected PMPY cost. Aon Hewitt will calculate the PMPY

expense by dividing the total amount of LM program fees paid by the number of LM participants, similar to the DM method.

Aon Hewitt will calculate the LM ROI by dividing the expected PMPY cost amount by the PMPY expense amount using the following formula:

$$\frac{\text{* Lifestyle Management PMPY Costs}}{\text{Lifestyle Management PMPY Expenses}} = \text{Lifestyle Management ROI}$$

* Indicates forecasted costs that are based on the Risk Value Table.

Benefits Administration will compare the LM ROI to the ratio requirement in the contract. If Healthways does not meet the minimum ROI, Healthways will be required to refund a percentage of the LM program fees. The ROI minimums for the LM program and the amount of program fees that Healthways will be required to pay back can be found in Table 6.

Table 6
Lifestyle Management Program Minimum ROI and Amount of Fees to Be Refunded if Not Met

Year	Year 1 (2013)	Year 2 (2014)	Year 3 (2015)	Year 4 (2016)	Year 5 (2017)
Minimum ROI Ratio	---	---	1 to 1	1.5 to 1	2.0 to 1
Fees at Risk	---	---	100%	100%	100%

Source: Contract between the State of Tennessee and American Healthways Services, LLC (pg.53, 56) ; RFP proposal.

Observation

2. Benefits Administration is in the process of conducting a clinical review of the Partnership Promise and has not obtained an Outcome Measures Report from Healthways

In 2013 and 2014, Benefits Administration told the Fiscal Review Committee that it would conduct its own internal clinical review of the Partnership Plan to determine whether or not Healthways is meeting its performance measures. In 2013, the Fiscal Review Committee asked Benefits Administration "***Has the State conducted an audit of the Contractor yet***?" On September 17, 2013, Benefits Administration submitted a written response to the Fiscal Review Committee stating,

> No, however, since the beginning of the contract, Benefits Administration staff performs analytical reviews on the monthly invoices. We review the invoices for duplicate charges and do periodic recalculations of the invoices based on supporting documentation provided by Healthways. Benefits Administration will conduct a clinical review in Q1 2014.

A year later, on September 30, 2014, the Fiscal Review Committee asked Benefits Administration about the progress of the clinical review stating, "***Did Benefits Administration conduct a clinical review of Healthways? If so, what were the results? If not, why has this not been conducted?***" Benefits Administration responded with the following measures that are listed in the contract,

> Benefits Administration is in the process of conducting a clinical review of the Partnership Plan. The 2014 biometric data is not yet available in our Decision Support System. Preliminary findings based on claims data show that:
>
> - The acute admit rate per 1,000 for the five chronic diseases where disease management is utilized is lower in the Partnership Plan membership than the Standard Plan membership;
> - The emergency room visits rate per 1,000 for the five chronic diseases where disease management is utilized is lower in the Partnership Plan membership than the Standard Plan membership;
> - Members in the Partnership Plan have higher preventive screening rates compared to members in the Standard Plan. Members in the Partnership Plan have a:
>
> - 81% screening rate for breast cancer vs. 59% in the Standard Plan;
> - 78% screening rate for cervical cancer vs. 60% in the Standard Plan;
> - 54% screening rate for colon cancer vs. 39% in the Standard Plan;
> - 91% screening rate for diabetes vs. 84% in the Standard Plan.

During our review, we were provided with the same preliminary findings that Benefits Administration submitted to the Fiscal Review Committee. Although the preliminary analysis provided some insight into the program's performance from 2011 to 2013, it is not a finalized clinical review because it does not contain data from 2014. As of October 2015, Benefits Administration has yet to release a comprehensive clinical review of the Partnership Plan.

Even though Benefits Administration is conducting its own internal clinical review, the Wellness Program's contract requires the vendor, American Healthways Services, to provide its own analysis of performance measures and submit the findings in an annual report to the state. According to the contract, the Outcome Measures Report must contain, at a minimum: a list of outcome measures, the clinical measures, the expected outcome, if the target was met, and if the target was not met, the reason that the target was not met and proposed improvement activities. In October 2015, when auditors inquired about the Outcome Measures Report, Benefits Administration staff reported that it was in the process of working with Healthways to create a template for the report. Once the template is complete, the Outcome Measures Report will be released, expected in late 2015.

It is important that Benefits Administration finish conducting its own internal clinical analysis so that it can determine whether or not Healthways is progressing towards meeting its performance measures. It is also important that Benefits Administration finish the template for

the Outcome Measures Report and request the report from Healthways to ensure that the progress of each outcome is tracked by Healthways, and that Healthways is taking steps to improve its performance if the outcomes are not met for each year. Benefits Administration and Healthways' lack of monitoring may prevent the discovery of weaknesses in Healthways' performance. Furthermore, because Healthways is using self-reported biometric data to identify members for coaching (see prior finding on Coaching Selections), Benefits Administration staff should take steps to ensure the data used in analyses is reliable, and is based on Physician Screens, otherwise, the results may be unreliable.

Benefits Administration should finish analyzing the 2014 biometric data, complete its clinical review of the Partnership Plan, and submit its findings to the Fiscal Review Committee. The division should also quickly finalize the template that will be used for the Outcome Measures Report and provide it to Healthways so that Healthways can meet its contractual obligations as well as track the progress of its performance.

Management's Comment

We concur. For clarification, these are two separate reviews. In September 2015, BA provided to the Insurance Committee a program review of the Partnership Promise, which included clinical measures. The outcome measures report cannot be completed until the data are available and methodology finalized. This review is in process. Once BA and Healthways agree on the results for all five measures, Healthways will provide BA with the required Outcome Measures report.

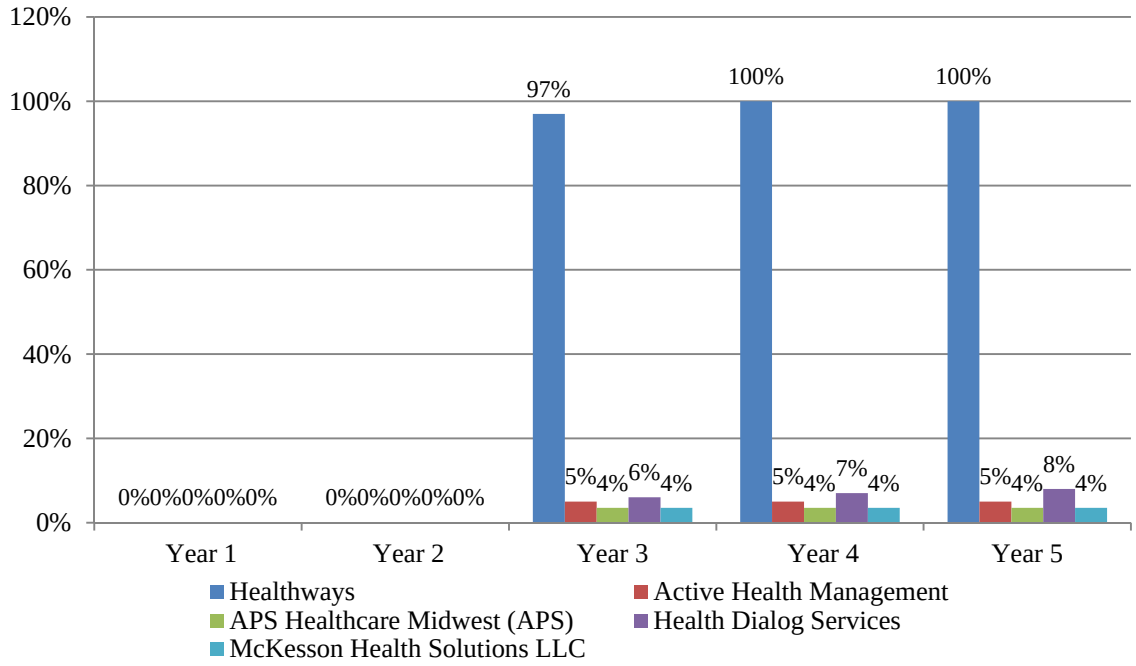
Observation

3. Benefits Administration should carefully review the Disease Management and Lifestyle Management programs' return on investment calculation to ensure that the ratios are calculated correctly and the calculation process is objective

During our review, we learned that the methodology that will be used for calculating the return on investment (ROI) ratios for the Disease Management and Lifestyle Management programs was created by Healthways. After the methodology was created, Aon Hewitt reviewed and approved it based on its professional opinion. Because Benefits Administration allowed Healthways to be directly involved in the development of the ROI methodology and because Healthways is the only entity with complete access to member data, the potential exists for Healthways to develop a methodology that may produce results in its favor.

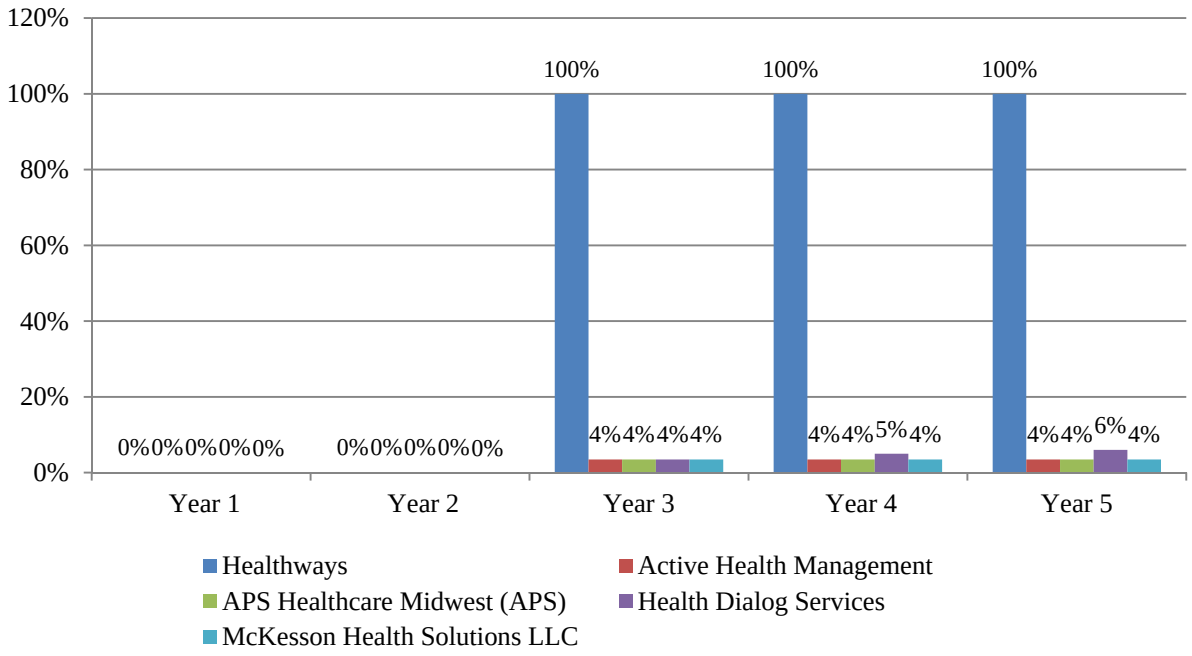
In addition, of the five vendors that submitted a bid for the wellness contract, Healthways was willing to risk refunding the highest percentage of program fees for not meeting the minimum ROI ratios. While other vendors were willing to pay back between 4% and 8% of program fees, Healthways agreed to pay back between 97% and 100% of its program fees. Charts 1 and 2 illustrate the different percentages of program fees that each vendor was willing to refund.

Chart 1
Percentage of Disease Management Program Fees Vendors Were Willing to Risk If Disease Management ROI Is Not Met



Source: RFP cost proposals submitted by American Healthways Services, LLC; Active Health Management; APS Healthcare Midwest; Health Dialog Services; and McKesson Health Solutions, LLC.

Chart 2
Percentage of Lifestyle Management Program Fees Vendors Were Willing to Risk If Lifestyle Management ROI Is Not Met



Source: RFP cost proposals submitted by American Healthways Services, LLC; Active Health Management, APS Healthcare Midwest; Health Dialog Services; and McKesson Health Solutions, LLC.

Because Healthways is willing to risk a large amount of program fees if it does not meet the ROI ratio requirements, it is essential that Benefits Administration carefully review the ROI calculations and Healthways' involvement and verify the data used for the calculation to ensure the results of the calculation are fair and unbiased. Benefits Administration should exercise its contractual rights and gain full access to the unfiltered state account data and additional necessary information, and confirm that a proper, unbiased dataset is used in the calculation. Since the cost value is determined by both members with mitigated or reduced risks (savings value) and members with unmitigated or incurred risk (costs), care must be made to ensure the dataset used is valid and representative of the state's account. Although Benefits Administration has access to Healthways-supplied data, with member identifiers removed, it does not have the algorithms or the associated business rules, so it can only perform a limited comparison of the data.

Management's Comment

We concur. Over the course of the contract, Benefits Administration, Healthways and Aon Hewitt have had frequent and extensive communications with Healthways to identify and require modifications based on BA and Aon Hewitt's evaluation of the Healthways methodology. In addition, Benefits Administration discussed with Aon Hewitt the methodology and our recommended changes during regularly scheduled meetings with Aon Hewitt. Aon Hewitt will evaluate both DM and LM ROI by validating the risk/value table calculations to convert the national data to create a risk/value table specific to State of Tennessee. They will also

validate the ROI calculation results using the DM and LM ROI methodology as revised by BA and Aon Hewitt.

Observation

4. In view of research that suggests that certain components of wellness programs have little impact on lowering medical costs for employers and do not produce a significant return on investment, the department should review the effectiveness of the program

Research indicates only the disease management component of wellness programs positively lowers employers' healthcare costs and the lifestyle management component has little to no impact on employers' healthcare costs. In January 2014, a leading health journal, *Health Affairs*, released a study that it conducted on PepsiCo's Healthy Living Wellness Program. Using data from 2004 to 2011, the study assessed the cost impact of the program's disease management component on PepsiCo's employees with chronic conditions, and the lifestyle management component for reducing employees' health risks. The PepsiCo Healthy Living Program, which is similar to Tennessee's Partnership Program, involved employees taking a health risk assessment, followed up with a disease management or lifestyle management program, and having access to a 24/7 nurse advice line. This study is significant because the results are specific to individual components such as DM and LM, and according to the study, is supported by two other recent studies, *the RAND Workplace Wellness Programs Study* (2013) and *The effectiveness of a health promotion program after 3 years: evidence from the University of Minnesota* (2012).

Conclusions of Health Affairs' research included that the disease management component of the program decreased health care costs and had a net savings. However, the lifestyle management component had no significant effect on healthcare costs although it did result in a small reduction in employee absenteeism. Health Affairs estimates that the lifestyle management component returned only $0.48 for every dollar PepsiCo invested, but the disease management component returned $3.78 for every dollar invested. Because PepsiCo only received $0.48 on every dollar that it spent for the lifestyle management program, the program actually cost more to run than it recovered in anticipated future savings.

According to Health Affairs, its findings from the research correspond with findings from two other studies: The RAND Workplace Wellness Programs Study and a 2012 study conducted by the University of Minnesota. Both found that wellness programs' lifestyle management component did not significantly reduce healthcare cost, but that disease management programs did result in a decrease in healthcare costs for employers. The research findings regarding lifestyle management programs are notable because the programs are similar to those in the state's wellness program.

Because some research has shown that wellness programs' lifestyle management component does not yield a high return on investment, and the observed trends of increased participation in LM and decreased participation in DM, the state should carefully consider the

effectiveness of this program, how it is serving the insured population, and verify any reported cost savings.

Management's Comment

We concur in part. Evidence-based research about wellness plans is still inconclusive. Our program's focus on disease and lifestyle management is an investment made to reduce the costs associated with the advance of chronic disease due predominantly to controllable lifestyle choices. When BA initiated this program in 2011 the most solid evidence about the efficacy of wellness programs was positive and promising. Subsequent industry studies about the cost-effectiveness of such efforts in other employer-sponsored plans, however, are not conclusive-some in support, others not. What is critical, therefore, is that **our** program has aggressive outcome measures built into the contract and that we measure **our** own return on investment as well as other measures of outcomes.

Aon Hewitt noted in their January 2014 response to the RAND study of PepsiCo's Wellness Program, the implication from the PepsiCo article and the RAND study is "that organizations risk little by doing nothing with their lifestyle management programs; this cannot be further from the truth. With respect to healthcare costs, LM programs proactively protect the bottom line by keeping people healthy, reducing at-risk behaviors and minimizing the severity of disease... Again, it should be noted the important roles risk reduction and behavior change play in the long term improvement of population health." In fact, a conclusion in the same PepsiCo study article states "Workplace wellness programs have the potential to reduce health risks and to delay or avoid the onset of chronic diseases as well as to reduce health care cost in employees with manifest chronic disease….Should not take for granted that such programs can reduce health care costs or even lead to net savings." We agree that employers and program managers should not take for granted that these programs will produce savings. That is exactly why we have outcomes measures in our contract.

WELLNESS PERFORMANCE SURVEY

In December 2014, the Division of Benefits Administration sent a web-based survey to a sample of state plan Partnership Promise participants to gauge their experience with the program. The division sent the 26-question survey to 2,000 heads of contract. Questions addressed each member's experience with the biometrics screening process, Well-Being Assessment questionnaire, and the coaching program. Respondents were also invited to provide comments.

Benefits Administration received 841 responses, resulting in a response rate of 42%. The survey and results are in Appendix 4 on page 75. Of the 1,121 responses received to question 25, "How would you describe your overall experience with the wellness program?" the most frequent choices—accounting for 62% of responses—were "I don't see the benefit for myself personally" (228), "I feel like my health is good and I just do what I'm asked to do" (225), and "The program is good for those who need it" (241). Our review of the responses and comments noted the following observations in the areas noted.

Concerns - Specific Questions and Comments

Biometric Screening

Of the 840 members responding to Question 1, "How did you get your biometric screening this year?"

- 68% had their biometric screening at their healthcare provider in lieu of a workplace screening.

Of those who chose to have a workplace screening,

- 89% found the process easy or very easy, and 86% found the location convenient or very convenient.

For the respondents who chose their own healthcare provider, getting the biometric data submitted posed challenges for some:

- 8% found it difficult or very difficult to download the form;
- 40% indicated they had run into some sort of difficulty in submitting the form; and
- the most commonly chosen responses were having to send the form multiple times, or discovering that the form had not been received when the member thought it had been.

Coaching

Concerning Question 10, "During the past 12 months, have you participated in the Healthways health coaching program?"

- 91% of respondents answered this question; and
- 67% percent of those surveyed had been contacted to participate in coaching.

According to Benefits Administration, as of February 2015, 52% of plan members overall were required to participate in coaching.

Of the 503 responses to Question 15, "Do you speak to the same coach each time?"

- 13% (63 respondents) responded yes;
- 47% (234 respondents) replied they hardly ever or never spoke with the same coach; and
- 41% (205 respondents) replied more often than not or nearly half of the time, they speak to the same coach.

Benefits Administration staff described the coaching one-on-one relationship as a program strength and motivator of participants; however, the answers to the question indicate a small percentage of the population surveyed had this experience.

Respondents to Question 17, "How would you describe your coaching experience?" could check all applicable answers; 506 respondents chose 817 answers. Results show that

- 42% (210 respondents) indicated that they are just participating in coaching to satisfy their requirements;
- 41% (208 respondents) indicated they can speak candidly with their coach;
- 28% of responses reflect positive choices such as "The coach motivates me and has influenced me to change," and "Coaching has helped me improve my health";
- 20% of responses reflect negative choices such as "The coach did not provide meaningful or useful information and suggestions," and "The coach has not motivated me or influenced me to change"; and
- 2% of the respondents indicated not being truthful with their coach.

Suggestions for Future Surveys

We have a few suggestions for improving the response rate and quality of future surveys about the wellness program. The survey email to respondents did not specify a date by which to complete the survey, although Benefits Administration says members were given until December 19 to complete it. (The initial email was sent December 4.) Additionally, the email did not contain a name or contact information to call if there were questions.

Benefits Administration should test the survey to ensure the questions and directions were understandable and would provide reliable information. It chose the sample from heads of contract (state employees) in the state plan although higher education employees were excluded. As of January 2014, there were a total of 70,093 heads of contract for state and higher education. It also excluded the spouses of the heads of contract. To get a more complete perspective of participants, all state plan enrollees and their spouses should be included.

Department's Comments for Clarification Regarding the Wellness Performance Survey

We concur with the recommendation that the survey should include a broader sample of the population. We will research cost effective ways to achieve this. The random sample was limited to state employee (head of contract) because that is the only population for which BA has email addresses. We do not have email addresses for all higher education employees or the enrolled spouse.

OFFICE FOR INFORMATION RESOURCES

The Office for Information Resources (OIR) (effective November 16, 2015, OIR is Strategic Technology Solutions) manages the information needs of state government and is responsible for providing direction, planning, resources, execution, and coordination for managing the information systems needs of the state. As a division within the Department of Finance and Administration, OIR provides services to state agencies, departments, and commissions. OIR serves as staff to the Information Systems Council (ISC) and, under the ISC's guidance, provides technical direction, resources, and infrastructure to the state. Currently, OIR is administering two department programs—Next Generation Information Technology (NextGen IT) and workstation support consolidation.

Next Generation Information Technology

As part of the current administration's Customer Focused Government plan and the implementation of recommendations from a 2012 assessment of existing state agency IT divisions, OIR oversees the Next Generation Information Technology initiative. NextGen IT focuses on improving and strengthening the state's IT environment. NextGen IT includes standardized IT organizational structure, job classifications, and processes. In conjunction with NextGen IT, the IT Academy training program offers state IT staff onsite, instructor-led classroom training, online live training, and web-based training.

As of August 2015, the Department of Finance and Administration and the Department of Financial Institutions have completed NextGen IT. The following departments were in process: the Department of Transportation, Tennessee Bureau of Investigation, the Department of Revenue, the Department of Health, the Department of Human Services, and the Board of Parole.

Workstation Support Consolidation

In compliance with Executive Order No. 39, Consolidating Workstation Support for Executive Branch Departments, the Customer Focused Government initiative and the Office for Information Resources have begun the consolidation of workstation support staff and activities for the state's executive branch agencies. Expected benefits of the consolidation include cost savings, increased security, increased productivity, and a manageable hardware replacement cycle.

As of July 2015, a total of 10 agencies had completed workstation consolidation: the Department of Finance and Administration, the Department of Human Services, the Department of Financial Institutions, the Department of Veterans Services, the Department of Human Resources, the Department of Labor and Workforce Development, the Department of Economic and Community Development, the Department of General Services, the Tennessee State Museum, and the Department of Tourist Development. The following agencies are to complete workstation consolidation by November 1, 2015: the Department of Children's Services, the Department of Transportation, and the Department of Agriculture.

Disaster Recovery

Information Systems Council (ISC) Policy 9 assigns responsibility for the State of Tennessee's disaster recovery programs to the Office for Information Resources (OIR) and to state agency management. OIR's responsibilities include (1) developing and recommending to agencies the standards, procedures, and guidelines necessary to ensure recovery capabilities for the state's information systems, and (2) providing management and support activities to agencies to assist them in fulfilling their disaster recovery roles. State agency management responsibilities include establishing (1) policies and procedures for the development of the agency's disaster recovery plan, and (2) recovery procedures for the agency's critical information systems, and designating an agency disaster recovery coordinator.

In the April 2011 audit, we recommended that OIR develop and implement standards and procedures to ensure OIR compliance with its ISC Policy 9 requirements. Our follow-up work during this audit found that OIR has provided centralized guidance to assist state agencies in their disaster recovery planning. For example, OIR created and made available to state agencies a template for preparing their disaster recovery plan. Agencies were provided procedures to identify their critical information systems to ensure continuity of operations in case of a disaster. OIR designated a disaster recovery coordinator to administer disaster recovery processes. The coordinator met with agency management and held town hall meetings so that agencies would have an understanding of OIR disaster recovery services available to them.

The disaster recovery objectives in this audit were to determine if state agencies have provided OIR with their disaster recovery plan, if OIR tests the plans and documents results, and if agency management and information technology directors understand their disaster recovery responsibilities under ISC Policy 9.

We obtained and reviewed documentation for agencies with OIR disaster recovery service plans, interviewed OIR staff and agency IT directors, and reviewed OIR disaster recovery testing documentation.

We interviewed representatives of nine state agencies to obtain their understanding of their responsibility to prepare for disaster recovery under ISC Policy 9 and the disaster recovery assistance provided by OIR.

Based on our audit procedures, we determined that

- OIR conducts semi-annual disaster recovery testing for the state's distributed systems,
- management of the agencies interviewed understand their responsibility for disaster recovery planning pursuant to ISC Policy 9,
- not all agencies with OIR disaster recovery services are participating in OIR disaster recovery testing, and
- not all state agencies have a disaster recovery plan and/or disaster recovery services for their IT systems.

Finding

6. Some state agencies do not have disaster recovery plans, and agencies with OIR disaster recovery services are not participating in disaster recovery testing, putting sensitive information at risk in the event of a disaster

An effective disaster recovery plan is documented and designed to quickly reestablish a system following a service interruption or disaster, resulting in minimum loss to the organization. Testing disaster recovery plans is the most effective way to make sure procedures are in place and to estimate the time of recovery without having the stress of a real disaster or outage. If agencies do not have a disaster recovery plan and do not test the plan, the result could be extended unavailability of government services critical to the safety and welfare of the general public, as well as the day-to-day operations of state government.

When we interviewed the information technology staff and management of nine state agencies, we found that two of the nine did not have an IT disaster recovery plan. Based on information obtained during agency interviews and documentation from OIR, auditors determined that it is highly likely there are other agencies that do not have an IT disaster recovery plan.

According to documentation obtained from OIR, 15 departments, boards and commissions, and executive and judicial offices have OIR disaster recovery service agreements that include disaster recovery testing. OIR conducts disaster recovery testing twice a year (industry best practice is one test a year). Of the 15 agencies with service agreements, our review of testing results for calendar year 2014 (the most recent calendar year for which results are available) included participation from the Department of Finance and Administration, the Office for Information Resources, Department of Health, and Department of Economic and Community Development. Therefore, not all agencies are testing their disaster recovery plan. Periodic disaster recovery plan testing can expose any issues that may arise during an actual emergency and, thereby, prompt the development of new procedures to ensure the disaster recovery plan will work as needed in an emergency. While disaster recovery testing is not required of state agencies, by declining to participate in disaster recovery testing, state agencies are putting sensitive information and critical information systems at risk in the event of a disaster.

Under current ISC policy the responsibility for creating policies and procedures for the development of the agency disaster recovery plan, establishing a disaster recovery coordinator, and establishing recovery procedures for peripheral activities falls onto state agency management. However, the policy does not establish who has oversight to ensure the responsibilities are being met. Currently, OIR provides centralized services for the state infrastructure and state agencies are de-centralized in managing disaster recovery plans and testing. Because of this hybrid system, state agency management falls into a false sense of security in having OIR available; however, OIR does not have the authority to review, approve, and hold agency management accountable for disaster recovery plans and testing. State agencies that have not established policies and procedures for the development of a disaster recovery plan

and have not established recovery procedures put the agency at risk of losing critical information and not being able to respond to customer needs in the event of a disaster.

Recommendation

We recommend that the Office for Information Resources work with the Information Systems Council to further define expectations for agency management regarding disaster recovery testing among state agencies. Agency decision makers should also be accountable for their specific roles within the plan related to creating a plan and testing the plan's effectiveness. The ISC can leverage the knowledge and systems contained by OIR to provide state agency management with a review, approval, and testing process to ensure information is available for state agency staff and OIR in the event of a disaster.

Management's Comment

We concur. Strategic Technology Solutions (formerly the Office for Information Resources) in the Department of Finance and Administration is consolidating information technology services for a number of executive branch agencies. STS will emphasize disaster recovery planning and testing with those agencies by stronger involvement with both the agency Management Advisory Committees and the newly formed Business Domain Management Advisory Committees. Non-participating agencies will continue to receive guidance and recommendations concerning the importance of disaster recovery programs. While STS does not have the authority to direct agencies' spending for disaster recovery, we will make our best effort to convey the importance of appropriate disaster recovery capabilities for critical systems. In addition, status of efforts in disaster recovery efforts and challenges will be shared with the ISC.

Information Systems Council Policy Review

The Office for Information Resources procedure "Review of Information Systems Council Policies" requires each ISC policy to be reviewed and assessed biennially, with a written report presented to the ISC at a regularly scheduled meeting with recommendations for the council's consideration.

The objectives of our review were to determine if the review is documented in ISC meeting minutes, if OIR has a written report of the biennial reviews, and if the written report includes requirements listed in the procedure. We found

- policy changes are documented in the ISC meeting minutes;
- for one of two biennial reviews completed, OIR has a written report; and
- for one of two biennial reviews, the written report contains items listed in the procedure.

Finding

7. The Office for Information Resources has not always followed its procedure for a biennial review of all Information Systems Council policies

The Office for Information Resources (OIR), serving as staff for the Information Systems Council (ISC), has not complied with the procedure it instituted for the systematic review and updating of ISC policies. The procedure requires a biennial review and assessment of each policy with a written report. The first biennial review was completed in October 2011; however, the next review was not completed until December 2014. In addition, OIR does not have a written report for the October 2011 review as required by the procedure.

The ISC is the statutorily created governing body for information technology in Tennessee. Section 4-3-5503, *Tennessee Code Annotated*, designates OIR to serve as staff to the ISC, assisting the council with its statutorily defined duties and responsibilities—developing policy guidelines for the overall management of the state's information systems and periodically reviewing the effectiveness and efficiency with which the state's information systems network is managed.

The April 2011 Department of Finance and Administration performance audit recommended that OIR establish guidelines for a periodic review of the policies of the ISC. In response, OIR developed ISC-PR-001, "Review of Information Systems Council Policies." The ISC approved the procedure at its April 2011 meeting.

Procedure Requirements

Section 4 of Procedure ISC-PR-001 requires each ISC policy to be reviewed and assessed biennially. The review evaluates the status of implementation efforts, and assesses how well objectives are met and whether recommendations need to be made to the ISC to modify any policy. In addition, a written report by OIR's Chief Information Officer is required to be presented to the ISC at a regularly scheduled meeting with recommendations for the council's consideration.

Biennial Reviews and Documentation

Periodic review of ISC policies aids in ensuring that OIR fulfills its statutory responsibilities as staff to the ISC and supports the council in its duty to establish policy guidelines for the management of the state's information systems. A full review of all ISC policies was presented by OIR at the October 2011 ISC meeting, six months after the procedure was approved by the ISC. That review recommended revisions to two policies, and both were approved by the ISC. However, OIR does not have the written report of this review as required by the procedure.

To comply with the procedure, the next full review would be in October 2013. However, OIR executive management and subject matter experts completed the next policy review on

December 3, 2014, summarized in a written report and presented at the December 2014 ISC meeting. Three policy revisions were recommended by OIR and approved by ISC.

A revision to one ISC policy was approved at the November 2012 ISC meeting but was not the result of a biennial review of all policies. Therefore, OIR has not complied with its procedure calling for a review every other year.

Lack of Quorum at Meetings

OIR management said the lack of a quorum at ISC meetings has impacted its ability to conduct business—including policy review. The ISC met 14 times from January 2011 through December 2014. Of the 14 meetings, 3—February 2013, October 2013, February 2014—did not have a quorum present. The biennial reviews should have been completed and ready for presentation, regardless of having a quorum at the meeting.

Statute Changes

In September 2014, at its Sunset Hearing before the General Assembly's Government Operations Joint Subcommittee on Judiciary and Government, the written presentation for the ISC hearing documented the lack of a quorum at the meetings. Public Acts of 2015, Chapter 385, made changes to ISC statutes that require members attend 50% of the required meetings. If a member does not attend as statutorily required, the ISC chair reports the non-attendance to the member's appointing authority. OIR believes this change will improve attendance at the meetings.

Recommendation

The Office for Information Resources should comply with its procedure for the systematic review and updating of the policies of the Information Systems Council. Compliance should include a timely biennial review with a written report to support the revisions as recommended.

Management's Comment

We concur. Responsibility for administering the biennial review procedure has been assigned. (The employee previously responsible has retired.) An electronic repository has been established for the written review reports and documentation of ISC action on the policy revision recommendations.

State Agency Information Technology Procurement Process

The objective of our review was to determine the process for an agency to procure an information technology (IT) system. The IT procurement process involves several state

entities—the agency procuring the IT business solution, the Information Technology Assessment and Budget Committee, the Department of Finance and Administration's Office for Information Resources, the Central Procurement Office, and the Comptroller of the Treasury. These entities coordinate and develop a Request for Proposal, and obtain and evaluate prospective vendor bids.

We interviewed staff of and reviewed documentation obtained from the Department of Safety and Homeland Security, the Department of Finance and Administration's Office for Information Resources, the Central Procurement Office, and the Comptroller of the Treasury. See Appendix 7 for a flow chart of the IT procurement process.

Once an agency identifies projects needed to achieve its business and technology strategies, the Information Technology Assessment and Budget Committee reviews the plan. (The committee is composed of director-level staff within the Department of Finance and Administration's Office for Information Resources, Business Solutions Delivery Division, and Budget Division.)

Projects are evaluated by analyzing (1) cost components in development, implementation, and operation and (2) cost savings and improved services. Projects with an estimated cost of $5 million or greater are also reviewed by the Enterprise Portfolio Investment Committee. (See Business Solutions Delivery section below for a description of committee membership and responsibilities.) The Enterprise Portfolio Investment Committee reviews the investment, taking into consideration the agency portfolio requests, the Governor's priorities, business value proposition to the state, and IT enterprise implications. After its review, the committee makes recommendations to the Governor for inclusion in the Governor's budget. The committee also monitors the project performance through quarterly meetings and approves subsequent annual funding based on demonstrated progress. Projects with an estimated cost greater than $10 million are reviewed by the Information Systems Council. (See Finding 7 for a description of the council.) Results of these reviews are compiled in a disposition issued by the Information Technology Assessment and Budget Committee.

Projects are evaluated by analyzing all cost components in development, implementation, and operation as well as existing cost savings and improved services to be delivered. After the review, each agency head receives a disposition of the agency's plan with appropriate recommendations from the review committee. From this process, the department may submit a request for funding of any projects it has defined in the agency's plan. After review by the Information Technology Assessment and Budget Committee, the Enterprise Portfolio Investment Committee, and the Information Systems Council, the agency must obtain an Office for Information Resources endorsement. OIR conducts a review to ensure the system can meet technical standards, IT policies, IT operational models, and technology best practices. Once OIR's endorsement is obtained, the Central Procurement Office (CPO) reviews the Request For Proposal to ascertain whether the correct template has been used and if there are any deviations from the template. Then, staff of the Comptroller of the Treasury's Office of Management Services review the RFP to confirm that specifications in the proposal do not artificially limit the competition of the bidding process. The CPO then puts the proposal on the CPO website, and the agency evaluator reviews the bids received and selects the best evaluated proposal.

Following the selection of a vendor, the procurement process enters the "open file" period, and the vendor can modify the contract terms and conditions, which are reviewed by the Comptroller of the Treasury. Other vendors can also review the file and protest the decision. Barring any protests, signatures are obtained from the vendor and agency. The CPO provides the final approval of the procurement and sends the executed contract to the vendor.

Based on audit procedures, we determined the IT procurement process includes sufficient oversight and review.

Business Solutions Delivery Division and Implementation of Driver's License System

The Business Solutions Delivery (BSD) Division, created in 2011, provides centralized resources to assist state agencies with information technology implementation. The division also serves as staff for the Enterprise Portfolio Investment Committee (EPIC), whose membership includes the State of Tennessee's Chief Operating Officer (Committee Chair), the Commissioner of Finance and Administration, the Governor's Chief of Staff, and the Department of Finance and Administration's Budget Director. Staff to the committee includes the Chief Information Officer and the Director of BSD. EPIC is responsible for

- providing agencies an opportunity to present their IT solution needs as input to the budget process;
- implementing a formal process using standard information to enable enterprise cost analysis and prioritization of all Executive Branch project requests, based on the Governor's key priorities;
- promoting enterprise solutions across state government; and
- providing management evaluation of quarterly project performance relative to scope, schedule, budget, and risk with authority to make any necessary changes and/or end the project.

Business Solutions Delivery is state funded and does not charge for the services it provides. The division assists on project implementations that cost $10 million or more and offers web and class training to IT project managers in other state agencies. The division uses the Tennessee Business Solutions Methodology, which is a modified version of Project Management Body of Knowledge and Business Analysis Body of Knowledge, industry standards guides from the Project Management Institute and the International Institute of Business Analysis, respectively. As an example, the division assisted the Department of Safety and Homeland Security with the implementation of a new driver's license system, the A-List system, completed in 2015. We reviewed the documentation related to the procurement and implementation of the A-List system.

Upcoming projects for the division include IT systems development for the Department of Intellectual and Developmental Disabilities, the Department of Health, the Bureau of TennCare, the Department of Commerce and Insurance, the Department of Finance and Administration, the Department of Labor and Workforce Development, the Department of Revenue, the Department of Correction, the Department of Mental Health and Substance Abuse

Services, the Alcoholic Beverage Commission, the Department of Agriculture, the Department of Human Services, the Department of Children Services, and several boards and commissions. These projects are in the early stages of implementation or not initiated, and so they were not included in our review.

The objectives of our review of Business Solutions Delivery were to determine

- if goals and timelines were met during the Department of Safety and Homeland Security's A-List driver's license system implementation, and
- if BSD provided adequate assistance and resources during the Department of Safety and Homeland Security's A-List driver's license implementation.

To accomplish these objectives, we conducted interviews with Department of Safety and Homeland Security Information Technology leadership and staff to gain their perspective on timeliness and assistance provided to them by Business Solutions Delivery. Business Solutions Delivery provided periodic progress reports to the Department of Safety and Homeland Security leadership and staff during the A-List system implementation. The reports included status of tasks completed, in progress, and yet to be started, and concerns that the teams were experiencing.

Consulting Services Pre-Approval Process

In response to a finding in the April 2011 Performance Audit of the Department of Finance and Administration, the Office for Information Resources (OIR) instituted a new process for approval of consulting services used in conjunction with information technology commodities contracts. The "Consulting Services Pre-Approval Process" is described on OIR's intranet, with a link to the Consulting Services Request Form. Consulting services ordered from technology contracts must be in direct support of the hardware/software products. Examples are product installation, configuration, integration into the state's infrastructure, and product upgrades or conversions. The requesting agency completes and submits the form to OIR to obtain approval prior to using consulting services. The purpose of the consulting services request form is to ensure that the services portion of a commodities contract is used appropriately and for the direct support of the commodity.

The objective of our review was to determine whether OIR is complying with its consulting services pre-approval process. We interviewed OIR management, and reviewed approved requests for consulting services and contracts for hardware/software products. We determined that OIR complied with its consulting services approval process.

VOLUNTEER TENNESSEE

Volunteer Tennessee, whose mission is to encourage volunteerism and service across the state, was created in 1994 to qualify Tennessee to receive federal grants under the 1993 National and Community Service Trust Act.

Volunteer Tennessee serves as grants manager for federally funded grants through the Corporation for National and Community Service (CNCS), which funds AmeriCorps programs, known as the domestic Peace Corps. AmeriCorps service members serve full- or part-time; full-time members in the most recent grant year received a living allowance and an education award of $5,550 upon completion of 1,700 hours of community service in one of the programs. During the 2014-2015 grant year, the Volunteer Tennessee Commission subgranted $3,809,880 to 16 programs statewide with approximately 750 AmeriCorps members.

Volunteer Tennessee staff includes one full-time staff auditor who performs both programmatic and fiscal monitoring.

The objectives of our assessment of Volunteer Tennessee's monitoring process were to determine

- if Volunteer Tennessee is in compliance with the provisions of Central Procurement Office (CPO) Policy 2013-007, "Grant Management and Subrecipient Monitoring Policy and Procedures";
- whether current monitoring practices affect the efficiency of the process; and
- whether risk assessments appear to be reasonable measures of programmatic and financial risk.

To accomplish these objectives and to gain an understanding of Volunteer Tennessee's monitoring process, we interviewed Volunteer Tennessee staff and management. To gain perspective on the monitoring process, we interviewed staff of the Central Procurement Office and of the Office of Criminal Justice Programs. We reviewed Volunteer Tennessee's monitoring guides and the 2013, 2014, and 2015 monitoring plans, monitoring reports, risk assessments, and corrective action plans.

Based on our audit procedures, we determined the following:

- Volunteer Tennessee's program monitor follows federal CNCS guidance, using a series of guides to conduct thorough monitoring of the areas required under CPO Policy 2013-007.
- Volunteer Tennessee did not complete its CPO-submitted and approved monitoring plan for the 2013 or 2014 monitoring years by the end of the federal fiscal year. As of July 2015, Volunteer Tennessee is not on track to complete its 2015 monitoring plan by September 30, 2015, the end of the federal fiscal year. As a result, reports of

the previous year's findings that are required with each year's monitoring plan have not reflected an accurate or useful count.

- Volunteer Tennessee does not monitor contracts in the ongoing monitoring year, as recommended by the Central Procurement Office.
- Volunteer Tennessee has made multiple site visits to some subrecipients who did not produce requested documentation on the first visit.
- One grant in the contract population has not been monitored during the past two years and is not on the monitoring list for the current year.
- Volunteer Tennessee allowed one subrecipient to repay questioned federal costs in installments over a period originally planned to span nine months, but which exceeded that time period by at least two months. This subrecipient was known by Volunteer Tennessee to have weaknesses in accounting procedures and internal controls, and a subsequent audit questioned whether the subrecipient was a going concern (a viable business).
- The risk assessment form used by Volunteer Tennessee program managers does not yield scores that accurately reflect programmatic and financial risk.

Finding

8. Volunteer Tennessee has not completed its annual subrecipient monitoring plans timely; monitoring is performed after the contract year has ended; and one subrecipient was not monitored within a three-year period

Central Procurement Office (CPO) Policy 2013-007, "Grant Management and Subrecipient Monitoring Policy and Procedures," requires state agencies that award state or federal funds to subrecipients to develop and submit a monitoring plan to the CPO for review and approval annually by October 1. Policy 2013-007 states, "The monitoring plan is a summary of the agency's planned monitoring activities for the current annual monitoring cycle." Volunteer Tennessee monitors on the federal fiscal year (October 1 through September 30). Volunteer Tennessee did not complete monitoring by the end of the federal fiscal year for all subrecipients selected during either the 2013 or 2014 monitoring years.

Table 7
Volunteer Tennessee Monitoring Reports Issued
During and After Monitoring Years 2013 and 2014

Monitoring year	2013	2014
Issued during year	6	4
Issued after year end	7	3
Days issued after year end	51 - 310	62-142

Volunteer Tennessee is not on track to complete monitoring for all recipients on the monitoring list for the 2014-2015 monitoring year. Of nine selected contracts, Volunteer Tennessee has issued three reports as of July 28, 2015.

Because the majority of Volunteer Tennessee's monitoring for the year is not complete at the time the next year's monitoring plan is due, the agency is unable to provide a complete summary of findings for the previous year. This CPO policy requirement to attach a summary of findings is a reporting mechanism allowing CPO access to information about types and frequency of findings, and may serve as a tool to shape monitoring and training choices during the following year. A review of these yearly summaries showed that data from many reports was not captured in the summaries, negating its usefulness to CPO reviewers.

Monitoring After Contract Has Ended

According to verbal guidance provided to the auditors by the Central Procurement Office Grants Manager, agencies should monitor grants during the contract year. However, Volunteer Tennessee monitors contracts after the program year has closed. For example, the 2015 monitoring plan lists nine subrecipient contracts, all of which run from August 2013 through December 2014. Disadvantages to monitoring a closed program year enumerated by CPO include missing opportunities to advise subrecipients of rule changes during the current year, and the possibility of programs being out of compliance for a longer period of time. Several monitoring reports refer to repeat findings because monitoring reports were issued too late for problems to be corrected in the following year.

Monitoring the closed contract year compounds with delays in completing each year's monitoring plan to sometimes make the end of the time period monitored more than a year distant from the issuance of the report. Two direct effects of this are seen in adjustments of service hours of AmeriCorps members who have already graduated the program (see below) and in an increased risk if a need should arise to collect monies associated with questioned costs on closed contracts (see Finding 9).

Adjustments to Service Hours After Service Terms Have Ended

The monitoring report issued following a July 2014 compliance visit by CNCS stated, "The timing of … reviews [of subgrantees] sometimes results in adjustments being made to members' total service hours well after their terms of service have ended." Two common causes to adjust service hours are improperly conducted criminal history checks, and member timesheets that cannot be verified or that contain mathematical errors.

We examined all corrective action plans completed in response to monitoring reports from the 2013, 2014, and 2015 monitoring years to find instances of disallowed hours due to these two causes. We then assessed the frequency of exited members losing any part of an education award. Of the 18 completed corrective action plans this period, 12 plans (67%) showed disallowed hours for exited members, for a total of 3,967.25 hours. See Table 8.

Table 8 Hours Deducted from Education Awards of Exited Members Monitoring Reports Issued 2/1/2013 through 2/28/2015		
Total hours disallowed	3,967.25	
Result: Hours reduced; no effect on award/no award earned	1,322.25	33%
Result: Member already used award; reimbursement by subrecipient	2,410.5	61%
Result: Education award reduced for member	234.5	6%

Our observations echoed the CNCS report: Because of the time lag between the contract period reviewed and the date the monitoring report is issued, disallowed hours and any reduction in education award generally belong to former AmeriCorps members whose periods of service have ended. Education awards have been reduced or disallowed for individuals who have no option to make up any deficiency and restore the full value of the award. Additionally, one member was found eligible for a full-time education award which had not been awarded because of timesheet inaccuracies. In all, six exited AmeriCorps members had their education awards reduced with 234.5 total disallowed hours.

The implications to a subrecipient of disallowed hours are either no practical effect or reimbursement of the prorated value of the disallowed hours for education awards already used. The time between the program year monitored and completion of the corrective action plans is great enough not only for members to be exited, but for many of them to have exhausted their education awards upon completion of the program: the greatest number of disallowed hours fell in this group.

Multiple Site Visits

Subrecipients' failure to prepare for audits contributes to the delay in issuance of monitoring reports. Volunteer Tennessee's program monitor requests documents 30 days in advance of site visits yet finds the documents not yet ready on the day of the site visit. For ten subrecipients, the monitor made multiple visits over at least ten days. Six of the ten required two visits, and four required a third visit. Whether or not another site visit was required, 21 of 23 subrecipients delayed the process by not having one or more pieces of documentation available. Even after the monitor provides a draft of the monitoring report, subrecipients sometimes provide additional documentation related to findings or questioned costs, delaying the release of the report.

Volunteer Tennessee's grant monitor participates in annual training for subrecipients that includes grant requirements and supporting documentation required for expenditures. In the future, Volunteer Tennessee may benefit from emphasizing, during those annual training sessions, that the subrecipients should be prepared for the monitor's site visits. This would provide for more efficient use of the monitor's time and result in timely reports.

Subrecipient Not Monitored

Finally, we found one subrecipient in the contract population that has not been selected for monitoring on any of the last three plans. Policy 2013-007 states that all subrecipient grant contracts must be monitored at least once every three years.

Central Procurement Office Policy 2013-007 states, "Agency records obtained pursuant to this Policy shall be subject to evaluation by the Chief Procurement Officer or the Comptroller of the Treasury, or their duly appointed representatives." Based on our review of the policy, conversations with the CPO grants manager, and a review of the Office of Criminal Justice Programs' grants monitoring processes, we believe that best practices would include monitoring grants in the current contract year. Monitoring the closed contract year, combined with several months' delay in completing the monitoring plan, leads to reports that do not address subrecipient issues in a timely manner.

Recommendation

Volunteer Tennessee should adopt best practices by monitoring the current program year and addressing delays in issuing reports. Volunteer Tennessee staff should explore changes that would encourage or enable subrecipients to have documentation prepared for monitoring visits. Additional training of subrecipients may be necessary, and the program monitor may wish to consider disallowing costs or withholding funds for failure to produce requested documents.

Management's Comment

We concur in part. While we agree that there are disadvantages to monitoring after a contract has ended, there are also disadvantages to monitoring the current contract, including the possibility of non-compliance after the monitoring. In addition, programs monitored at the beginning of a current contract monitoring cycle would have only one or two months of transactions available to monitor. This limited source of information would prevent the development of a well-structured sampling methodology and could prevent the monitor from obtaining sufficient evidence to provide a reasonable basis for her findings and conclusions. Also, current contract monitoring would not be able to capture samples of one-time or infrequent expenses that occur later in the program year. Volunteer Tennessee does plan to increase program manager desk reviews on current contracts. This will increase the opportunity for programs to correct errors in the current year.

We concur in part that monitoring plans were not completed timely. Central Procurement Office (CPO) Policy 2013-007 does not include any explicit requirement for monitoring reports to be issued by the end of the fiscal year. Although some of the reports were not issued by the end of the fiscal year, Volunteer Tennessee did initiate monitoring of all sub-recipients during the monitoring cycle (Oct 1- September 30) for both 2103 and 2014 monitoring plans. Volunteer Tennessee's monitor was on track to finish onsite visits by September 30; however, some reports will be issued after September 30. This is due to additional guidelines from the Corporation for

National and Community Service (such as the Interim Guidance on Criminal History Checks) that became effective during the course of the current monitoring cycle. These additional guidelines required the monitor to significantly expand her samples and review additional documentation. We agree, however, that issuing reports during the monitoring plan year is a best practice and will move to do so.

We concur that additional training of subrecipients may be necessary. Additional emphasis during sub-recipient annual training on the importance of being prepared for the monitor's site visits may yield results and we will move to do so. We also agree that disallowing costs for failure to produce requested documents may improve the timeliness of document submission. Volunteer Tennessee will disallow costs for failure to produce requested documents in a timely manner during the FY16 monitoring cycle; however, we do have concerns that this may simply result in shifting the responsibility for reviewing documentation from the monitoring phase to the resolution phase. Withholding funds for failure to produce requested documents would require policy change and additional contract language, and it is not clear that such actions would be feasible.

We concur that one sub-recipient was not monitored within the three-year period reviewed. This agency was unintentionally not monitored due, in part, to a data entry error on Volunteer Tennessee's monitoring tracking sheet. A staff member marked the agency as being part of the FY13 monitoring plan on the monitoring tracking sheet although the agency was not included in that plan. This was further compounded when another staff member, who was new at the time, incorrectly tracked this agency's FY12 response as the FY13 response, which gave the appearance that the FY13 monitoring had been completed. Since that time, Volunteer Tennessee implemented a monthly review of the status of monitoring and monitoring resolution. The agency is included on the FY16 monitoring plan.

Finding

9. Volunteer Tennessee has not monitored the 2015 contract for a subrecipient it identified as having solvency concerns; this subrecipient also was allowed to pay questioned costs in installments over a period of time

One subrecipient's monitoring report for the 2014 grant year, issued April 23, 2015, observed that the subrecipient's "[e]xcess of current liabilities over current assets is an indicator that the agency may not be solvent." The same report included a finding for the agency's failure to provide requested documentation for test work on periodic expense reports. Questioned costs totaled $72,778: $17,080 in federal funds and $55,698 in subrecipient's matching funds.

Based on history, we expect the amount of questioned costs to be reduced under the corrective action plan, upon the subrecipient's production of documentation. However, even a much smaller amount owed by this subrecipient presents a risk of non-repayment, since the agency may not be a going concern. Further, this subrecipient asked to pay over time when $4,099 in disallowed costs resulted from a November 25, 2013, monitoring report. Volunteer Tennessee's final corrective action plan for that amount was to accept monthly payments of

$500, with repayment expected to be complete by April 2015. As of September 2015, the full amount has been repaid.

In addition to questioned costs from the April 23, 2015 monitoring report, another contract year, 2015, remains to be monitored, creating a potential for further disallowed amounts. This subrecipient did not apply for a grant for the 2016 program year.

Recommendation

Volunteer Tennessee should monitor this subrecipient closely while continuing to obtain documentation and accurately determining disallowed costs for 2014 and later for 2015. If the subrecipient is unable to make a payment for the full amount of disallowed costs, Volunteer Tennessee should withhold the owed amounts from funds payable on current contracts.

Management's Comment

We concur. The subrecipient's 2015 contract has not yet been monitored; however, it is included in Volunteer Tennessee's current monitoring plan. The subrecipient was allowed to pay 2013 questioned costs over a period of time, and all of those questioned costs were recovered. The subrecipient is a small non-profit agency with limited cash reserves. Demanding full payment may have forced the agency into bankruptcy, which would have negatively impacted the community served by the agency and made recovery of the questioned costs difficult at best. Therefore, Volunteer Tennessee determined that the most responsible course of action was to allow payments over time. Volunteer Tennessee has resolved the 2014 finding that resulted in $17,080 being questioned for the sub-recipient, with no costs being disallowed. During the resolution of the monitoring report, the sub-recipient was able to provide documentation to support all costs included in the questioned sample.

Analysis of value and feasibility of recommendation:

Volunteer Tennessee agrees that there is potential for costs to be questioned and that the subrecipient should be monitored closely. In fact, after we complete the 2015 contract monitoring, Volunteer Tennessee will have monitored this sub-recipient four years in a row, specifically as a result of concerns about the agency. In addition to monitoring, Volunteer Tennessee program staff also provided intensive technical assistance and support for the subrecipient on an ongoing basis. During the 2014 monitoring cycle, the monitor included findings of questioned costs due to lack of documentation being provided during the fieldwork portion of the monitoring (much in the way recommended by the auditors in the previous finding). This review was conducted during a time of significant transition in subrecipient's Board and staff leadership, which challenged the agency's ability to provide documentation in a timely manner. Since the organization's leadership has now stabilized, we anticipate that documentation will be much more readily available when the 2015 contract year is monitored. Although the subrecipient was showing signs of improvement, our concerns were such that staff had already had discussions about recommending to the Volunteer Tennessee board not to fund

the subrecipient for 2016. As the auditors noted, the subrecipient decided on its own not to apply again for funding, so staff did not need to make that recommendation. In general, Volunteer Tennessee does withhold funds payable on current contracts to collect questioned costs and will continue to do so as recommended.

Observation

5. The risk assessment used by Volunteer Tennessee program managers does not yield scores that accurately reflect programmatic and financial risk

Volunteer Tennessee program managers evaluate each subrecipient prior to making monitoring selections using a risk assessment that was developed about 10 years ago from a model supplied by Program Accountability and Review (PAR), the state's former oversight entity for subrecipient monitoring. The Executive Director and the Deputy Director of Programs for Volunteer Tennessee acknowledged that this risk assessment is not useful in making monitoring selections because its design is such that all programs will be rated at low or medium risk. We recommend that Volunteer Tennessee improve its risk assessment by targeting areas of greatest risk, by lowering scoring thresholds for medium and high risk, and by eliminating subjective language when possible.

1. Target areas of programmatic and financial risk

According to Volunteer Tennessee management, the areas of greatest programmatic and financial risk include compliance with the Corporation for National and Community Service process for criminal history checks, accurate timekeeping, and proper documentation for expenses. These areas, though closely monitored, are not directly addressed by any questions on Volunteer Tennessee's assessment. Volunteer Tennessee's risk assessment should be rewritten to include questions that target the areas of greatest risk and to eliminate questions that may cause areas of lesser risk to be weighted too heavily.

2. Bring scoring in line with other risk assessment forms

Table 9 compares scoring for Volunteer Tennessee's risk assessment with the model provided by Program Accountability and Review and with the risk assessment form currently used by the Office of Criminal Justice Programs. Subrecipients must score proportionally higher in order to advance to medium or high risk under Volunteer Tennessee's scoring scheme.

Table 9 Comparison of Scoring by Risk Assessment Forms			
Risk Assessment Form	Sample	OCJP	Volunteer Tennessee
Number of questions	18	14	42
Possible scores:	16-97	21-85	40-221
Threshold, medium risk	36	28	110
Percent of maximum score	37%	33%	50%
Threshold, high risk	56	51	155
Percent of maximum score	57%	60%	70%

3. Eliminate subjective language when concrete criteria could be used

Volunteer Tennessee's risk assessment should include concrete examples or criteria rather than subjective descriptors for choices on the Likert scales. For example, a question on report submission could replace the choices "usually on time" and "sometimes late" with specific parameters such as "one late report over 12 months." When the question obligates the evaluator to make a judgment call in choosing the response, there is a greater risk of inconsistency, particularly if more than one person prepares risk assessments.

Management's Comment

We concur. Volunteer Tennessee agrees that the risk assessment tool currently being utilized can be improved to address the most significant areas of risk for Tennessee's AmeriCorps programs. For FY16, Volunteer Tennessee modified the existing risk assessment tool to more heavily weight certain fiscal and member-related indicators. This resulted in a significant increase in the percentage of sub-recipients assessed as medium (59%) and high (5%) risk compared to the 13% assessed as medium risk during the prior year. For FY17, Volunteer Tennessee plans to overhaul the tool in its entirety. The revised tool will focus much more heavily on indicators specific to the AmeriCorps program and less so on the organization's overall operations.

DIRECT APPROPRIATIONS MONITORING

Direct appropriations are legislative provisions in the annual budget that direct approved funds to specific agencies that are not part of state government. The objective of our review was to assess the status of direct appropriations monitoring. We interviewed department staff and pass-through agency staff, and we reviewed documentation. Based on our audit work, we

determined that there is not a formal monitoring system for direct appropriations, and recipients are not subject to the same controls and oversight by the pass-through agencies as grant recipients subject to the Central Procurement Office's (CPO) monitoring policy.

Finding

10. There is not an adequate formal monitoring system for direct appropriations (repeat finding)

Direct appropriations provide funding to agencies that are not part of state government (e.g., nonprofit organizations and quasi-governmental agencies) through a state pass-through agency. The pass-through agency disburses the funds after obtaining a signed letter of agreement from the direct appropriations recipient. Direct appropriations are subject to the same legislative process as regular appropriations.

Examples of direct appropriations are funds appropriated for the Tennessee Performing Arts Center and disbursed through the Arts Commission, or for the Future Farmers of America and disbursed through the Department of Agriculture. Language in the appropriations act contains only general instructions on how the funds are to be spent (e.g., "the sum of $xxx is for the sole purpose of making a grant to xxx in such amount to be used for assisting with their program" or "the department is authorized to make a grant of up to $xxx to xxx").

The total amount of direct appropriations was $8.3 million, $20.6 million, $11.5 million, and $15.4 million for fiscal years 2013, 2014, 2015, and 2016, respectively. See Appendix 5 for a list of direct appropriations by year.

Section 21 of the fiscal year 2016 Appropriations Act (2015 Public Acts, Chapter 427) has the only monitoring requirements for state pass-through agencies regarding direct appropriations to non-governmental entities:

> Notwithstanding any provision of this act to the contrary, a direct appropriation to a non-governmental agency or entity shall not be disbursed until the recipient has filed with the head of the agency through which such disbursement is being made a plan specifying the proposed use of such funds and the benefits anticipated to be derived therefrom. As a prerequisite to the receipt of such direct appropriation, the recipient shall agree to provide to the agency head, within ninety (90) days of the close of the fiscal year within which such direct appropriation was received, an accounting of the actual expenditure of such funds including a notarized statement that the report is true and correct in all material respects; provided, however, that the head of the agency through which such disbursement is being made may require, in lieu of the accounting as provided above, an audited financial statement of the non-governmental agency or entity. A copy of such accounting or audit, as the case may be, shall be filed with the Office of the Comptroller of the Treasury.

The above language has not changed since the fiscal year 2006 Appropriation Act. Each year, the Division of Budget provides the state pass-through agencies instructions for disbursing direct appropriations, including a standard letter of agreement form that contains the language above.

The lack of an adequate formal monitoring system for direct appropriations was a finding in the April 2011 performance audit for the Department of Finance and Administration. At that time, we recommended that the General Assembly consider adding language to each direct appropriation regarding the intended purpose with measureable outcomes. As an alternative, we recommended that the General Assembly require the state pass-through agency perform on-site monitoring and/or report results to the General Assembly.

Review of Pass-through Agency Documentation

We selected a sample of 31 from a population of 137 direct appropriations for the fiscal years ending 2013-2015 representing 3 of 18 pass-through agencies. We obtained from the pass-through agencies the signed letters of agreement and the documentation the recipients provided to comply with the Section 21 language—(1) file a plan specifying the proposed use of the funds and the benefits "to be derived therefrom," and (2) provide a notarized accounting of the expended funds or an audited financial statement. The plans submitted by the recipients were written letters with program narratives only or written letters with program narratives and budgets. The reports submitted by the recipients to report on the use of the funds were notarized accounting statements, compiled financial statements, audited financial statements, and letters with program narratives and/or a list of expenditures. All 31 had a plan before funds were sent and all had an accounting of funds.

According to pass-through agency staff, the required plans for the use of the funds and year-end reports are reviewed by fiscal or grant staff. One of the 31 direct appropriation recipients was monitored on-site by the pass-through agency. Because of the on-site monitoring, the pass-through agency found that the recipient had not provided required training to staff. If the pass-through agency relied only on accounting reports, this issue would not have been determined.

Central Procurement Office Monitoring Policy

CPO Policy Number 2013-007, "Grant Management and Subrecipient Monitoring Policy and Procedures," creates a decentralized and uniform contract monitoring approach for state agencies. The policy establishes contract monitoring requirements to ensure subrecipient compliance with the requirements of state and/or federal programs, applicable laws and regulations, and stated results and outcomes. (A subrecipient is the equivalent of a direct appropriations recipient.) Agencies submit an annual monitoring plan to the CPO for approval. The plan includes a list of the subrecipients that will be monitored during the plan year (policy requires subrecipients to be monitored at least once every three years) and a risk assessment for each subrecipient with an explanation of the criteria used to assign risk to subrecipients and their related contracts.

The policy exempts direct appropriations, however, without on-site monitoring using specific criteria and clearly expected outcomes, especially for direct appropriations that are large and/or have been given to the same grantees for multiple years, both the pass-through agencies and the Department of Finance and Administration cannot ensure that recipients are using the appropriations for their intended purposes.

Recommendation

The General Assembly may wish to consider adding language to each direct appropriation regarding the intended purpose of that appropriation, including clearly expected outcomes that are measurable and specifying that a state pass-through agency should perform on-site monitoring of grantees to ensure the grantees make efficient and effective use of direct appropriations and to avoid the appearance of open-ended grants of funds with little oversight or accountability.

The General Assembly may wish to consider directing the Department of Finance and Administration, in consultation with state pass-through agencies, to develop and implement requirements for on-site monitoring to ensure the direct appropriations recipients are using the funds to meet the General Assembly's intent for the appropriation.

Management's Comment

We concur. Since the recommendations are directed to the General Assembly for consideration and not the Department of Finance and Administration, management defers to the will of the General Assembly concerning these recommendations

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REPORTING EXECUTIVE- AND CABINET-LEVEL TRAVEL EXPENSES

The Department of Finance and Administration, under Section 4-3-1010(c), *Tennessee Code Annotated,* is required to post to the "official website of the state a report that contains all out-of-state travel and expense reimbursements made to the governor, any member of the governor's cabinet, and cabinet level staff." Reports include the purpose of the reimbursements and the person reimbursed. Amounts are posted quarterly, no later than 15 days following the end of each quarter and remain on the website until one month following the end of a Governor's term of office. Travel for the purpose of recruiting industry or economic development in the state may be excluded from reporting if, in the judgment of the department's commissioner, it could harm contract negotiations or result in a competitive disadvantage.

The objective of our review was to determine the department's compliance with reporting travel reimbursements as required by Section 4-3-1010(c), *Tennessee Code Annotated.*

To accomplish this objective, we reviewed the reports on the state website, and we interviewed department staff and Comptroller of the Treasury legal staff. Because the statute specifically says reimbursements, the reports contain travel costs only for reimbursement claims. However, some travel expenses such as airfare and meals can be paid for directly by using a state-approved vendor or with the use of a state-issued payment card. Those are not reimbursed and therefore are not reported on the website. Department of Finance and Administration staff indicated that their interpretation of Section 4-3-1010(c), *Tennessee Code Annotated*, is that only out-of-state travel and expense reimbursements are reported. (See Appendix 4 for the reimbursements reported.)

Based on our audit procedures, we determined that

- quarterly expense reports currently posted on the state website do not include all out-of-state travel expenditures; and
- the Department of Finance and Administration interpreted Section 4-3-1010(c), *Tennessee Code Annotated*, to only include expense reimbursements in quarterly reports and will continue to do so unless the statute is amended.

Finding

11. The General Assembly may wish to amend statute to include all out-of-state travel expenditures along with travel and expense reimbursements to improve reporting transparency

Part of the duties assigned to the Department of Finance and Administration includes the reporting of all out-of-state travel and expense reimbursements made to the Governor, any member of the Governor's cabinet, and cabinet-level staff. The reports generated and posted on the website by the department include reimbursements, as the statute dictates; however, we believe the citizens of the state would want full disclosure of the cost of all travel. Under the current system, travel costs that are direct expenditures are not included in the reporting. Examples of direct travel expenditures are airfare and meals which are paid for directly by using a state-approved vendor or with the use of a state-issued payment card. Those are not reimbursed and therefore are not reported on the website. According to department staff, the criteria used in creating and issuing the reports is expressly stated under Section 4-3-1010(c), *Tennessee Code Annotated*, which only includes out-of-state reimbursements. Purchases made by state agencies with state credit cards for out-of-state travel (i.e., plane tickets, hotels, meals) are no longer processed for specific individuals. While the department may be in compliance with a strict interpretation of statute, travel expenses incurred by the Governor, members of the Governor's cabinet, and cabinet-level staff, without a corresponding reimbursement, are not reported, creating a lack of transparency.

Recommendation

The General Assembly may wish to amend Section 4-3-1010(c), *Tennessee Code Annotated*, to include all out-of-state travel expenditures and reimbursements incurred by the Governor, any member of the Governor's cabinet, and cabinet-level staff to improve transparency of reporting state funds spent on behalf of the state and its citizens.

Management's Comment

We concur. The Department reports out-of-state travel reimbursements made to the Governor, the Governor's cabinet and cabinet-level staff in accordance with current state law.

STATE INSURANCE COMMITTEE, LOCAL EDUCATION INSURANCE COMMITTEE, AND LOCAL GOVERNMENT INSURANCE COMMITTEE

The State Insurance Committee, created by Section 8-27-101, *Tennessee Code Annotated*, is composed of the Commissioner of Human Resources, the State Treasurer, the Commissioner of Commerce and Insurance, the Comptroller of the Treasury, the Commissioner of Finance and Administration, a member appointed by the Board of Directors of the Tennessee State Employees Association, and three state employees. One state employee, who must be an employee of either the University of Tennessee or the state university and community college system, is selected under a procedure developed by the Tennessee Higher Education Commission and approved by the State Insurance Committee. Two state employees are selected in accordance with a procedure adopted by the State Insurance Committee, which is similar to that used to select the state employee trustees of the consolidated retirement system. The committee is authorized to enter into contracts for insurance benefits and related actuarial and consulting advice necessary to administer the plans for group insurance for state employees and retirees.

The Local Education Insurance Committee, created by Section 8-27-301, *Tennessee Code Annotated*, is composed of the Governor, who may designate the Commissioner of Education in his place; the State Treasurer; the Commissioner of Commerce and Insurance; the Comptroller of the Treasury; the Commissioner of Finance and Administration; a representative of local school boards to be selected by the Tennessee School Boards Association; and three teachers selected to represent the three grand divisions. This committee is authorized to contract for health insurance and related functions for local education employees. The Local Government Insurance Committee, created by Section 8-27-207, *Tennessee Code Annotated*, is composed of the Commissioner of Finance and Administration, the Comptroller of the Treasury, the State Treasurer, a member to be appointed by the Tennessee Municipal League, and a member to be appointed by the Tennessee County Services Association. This committee has authority to establish a health insurance plan for employees of local governments.

Auditors reviewed meeting minutes for 22 meetings, from February 2012 to May 2015. Auditors four attended meetings during audit field work. At each meeting, a quorum was present for each committee attending. Five of these meetings were attended by the State Insurance Committee only.

The committees received actuarial, financial, and legal information. They discussed and voted on procurements and contracts including those for health, dental, vision, life, and disability insurance for employees, and for communication, decision support, and pharmacy management contracts to support Benefits Administrations' work. The committees received financial reports on solvency targets for the plans and voted on rate and benefit changes. Changes to the benefits environment discussed or voted upon included changes brought about by the Affordable Care Act, the introduction of two pilot health programs and the Governor's Working for a Healthier Tennessee Initiative, transfer of location and outsourcing management/staffing for the State Employee Health Clinic, and planning and procurement for the new Consumer-Driven Health Plan, which is to include health savings accounts.

Table 10
State Insurance Committee, Local Education Insurance Committee, Local Government Insurance Committee
Members by Gender and Ethnicity as of July 31, 2015

Committee	Gender	
	Male	Female
State Insurance Committee	6*	5
Local Education Insurance Committee	4	5
Local Government Insurance Committee	4	1

*Reflects addition of the Tennessee Senate and House Chairs of the Finance, Ways and Means Committees effective 5/18/2015.

According to committee staff, the State Insurance Committee, Local Education Insurance Committee and Local Government Insurance Committee do not track ethnicity of members, and committee members are not required to sign conflict-of-interest statements.

STATE BUILDING COMMISSION

The State Building Commission, created by Section 4-15-101, *Tennessee Code Annotated*, is composed of the Governor, the Secretary of State, the Comptroller of the Treasury, the State Treasurer, the Commissioner of Finance and Administration, and the Speakers of the Senate and the House of Representatives. The Governor serves as chair, and the vice chair and secretary are selected by the members. The State Architect serves as the chief staff officer for the State Building Commission.

The Building Commission meets on the second Tuesday of every month to conduct business involving oversight of any improvement or demolition, acquisition or disposal

involving real property in which the State of Tennessee has an interest, except buildings or structures acquired by the Department of Transportation for highway rights-of-way. We reviewed minutes of meetings and viewed video recordings of meetings from January 2014 to July 2015; there were 19 meetings during this period, and a quorum was present at each meeting.

The commission hears presentations on building, demolition, and improvement projects and approves budgets, funding sources, selection of designers and contractors, and revisions to any of these elements.

Table 11
State Building Commission Members by Gender and Ethnicity as of July 31, 2015

	Gender		Ethnicity				
	Male	Female	Asian	Black	Hispanic	White	Other
Commissioners	6	1				7	

According to the State Architect, members of the State Building Commission and State Capitol Commission are not required to sign conflict-of-interest statements related specifically to membership on the commission; all are ex officio members who are required to sign conflict of interest statements as office holders.

STATE CAPITOL COMMISSION

The State Capitol Commission, created by Section 4-8-301, *Tennessee Code Annotated*, is composed of the Commissioner of General Services, the Comptroller of the Treasury, the Secretary of State, the State Treasurer, the Commissioner of Finance and Administration, the Commissioner of Environment and Conservation, the chair of the Tennessee Historical Commission, two legislative members (one each appointed by the Speaker of the Senate and the Speaker of the House), and three private citizens appointed by the Governor. The private citizens must include one person from each of the grand divisions of the state, one person 60 years of age or older, one member of a racial minority, and one black person. While the ethnic and age requirements for public members have been met, the two current members are both from middle Tennessee. The Governor appoints the chair of the State Capitol Commission. Actions of the State Capitol Commission are subject to the concurrence of the State Building Commission.

The State Capitol Commission meets as needed to address business, typically one to two times per year. We reviewed minutes of eight meetings from November 2010 to July 2015. There was a quorum present at all meetings. During the time reviewed, the chair of the Tennessee Historical Commission showed attendance rates below 50%;however, the chair of the Historical Commission has changed since the February 26, 2015, meeting, and the new chair attended the July 17, 2015, meeting. One public member has attendance rates under 50%;

however, this position has been held by two different individuals and is currently vacant. The public members holding the two remaining positions have attendance rates better than 50%.

During the time reviewed, the committee put in place a Capitol Grounds Master Plan and a Tennessee State Capitol Campus Monuments and Memorials Plan, approved placement for several monuments and markers on the capitol grounds, made arrangements to replace the decaying wood yoke of the Liberty Bell replica, and heard and made decisions on requests from governmental and non-governmental groups to use the capitol building and/or grounds for functions. Members of the commission have expressed a need for an updated policy to more clearly define what events may or may not take place in the capitol and on the capitol grounds. A consolidated use policy is being developed by the State Architect but has not yet been presented to the commission as of the last meeting, held July 17, 2015.

Table 12
State Capitol Commission Members by Gender and Ethnicity as of July 31, 2015

	Gender		Ethnicity				
	Male	Female	Asian	Black	Hispanic	White	Other
Commissioners*	10	1		1		10	

*Reflects vacancy of one public member.

APPENDICES

Appendix 1
Excerpts from the Healthways Contract Concerning Risk Assessments and Coaching

Contract provisions concerning the risk assessment algorithm and the state's access to and responsibilities for it:

> A.5 (h.) Wellness Scoring/Risk Assessment. **At the State's request** the Contractor shall submit to the State for approval its methodology for developing the wellness score and determining wellness/risk categories, including but not limited to, the factors used in the scoring, how those factors are weighted, the wellness/risk categories, the threshold for those categories, and the threshold for each program /type of intervention. The state reserves the right to review the methodology and require changes. Any changes to this methodology by the Contractor shall be prior approved in writing by the State. p.11
>
> A.6 (e) Identification and Enrollment in Lifestyle Management and Disease Management Programs At the State's request, the Contractor shall submit to the State recommended eligibility criteria and risk stratification procedures for each program (LM and DM) including but not limited to the data/information sources, the criteria for the target population, the factors used in the risk stratification and how those factors are weighted, the threshold for each risk level, and applicable timeframes for identification and risk stratification, by data source. p. 12
>
> E.8 State Ownership of Work Products. The State shall have ownership, right, title, and interest, including ownership of copyright, in all work products, including computer source code, created, designed, developed, derived, documented, installed, or delivered under this Contract subject to the next subsection and full and final payment for each "Work Product." The State shall have royalty-free and unlimited license to use, disclose, reproduce, publish, distribute, modify, maintain, or create derivative works from, for any purpose whatsoever, all said Work Products.
>
> (a) To the extent that the Contractor uses any of its own, or of any third party's pre-existing proprietary or independently developed tools, materials or information ("Contractor Materials"), the Contractor shall retain all right, title or interest in or to such Contractor Materials **EXCEPT** the Contractor grants to the State an unlimited, non-transferable license to use, copy and distribute internally, solely for the State's internal purposes, any Contractor Materials reasonably associated with any Work Product provided under the contract.
>
> (b) The Contractor shall furnish such information and data as the State may request, including but not limited to computer code, that is applicable, essential, fundamental, or intrinsic to any Work Product and Contractor Materials reasonably associated with any Work Product, in accordance with this contract and applicable state law.

Appendix 2
Partnership Promise Plan Coaching Fees Billed to the State

Service Provided and Risk Levels	Amount (per active participant per month)				
	Calendar Year 2013	**Calendar Year 2014**	**Calendar Year 2015**	**Calendar Year 2016**	**Calendar Year 2017**
Lifestyle Management Coaching					
N/A	$14.31	$14.74	$15.18	$15.64	$16.11
Disease Management Coaching - Chronic obstructive pulmonary disease					
High risk	$43.82	$45.14	$46.49	$47.88	$49.32
Moderate risk	$23.64	$24.34	$25.07	$25.83	$26.60
Low risk	$10.17	$10.48	$10.79	$11.12	$11.45
Disease Management Coaching - Coronary artery disease					
High risk	$52.57	$54.15	$55.77	$57.45	$59.17
Moderate risk	$28.58	$29.44	$30.32	$31.23	$32.17
Low risk	$11.57	$11.91	$12.27	$12.64	$13.02
Disease Management Coaching - Asthma					
High risk	$19.72	$20.31	$20.92	$21.55	$22.19
Moderate risk	$11.04	$11.37	$11.71	$12.06	$12.42
Low risk	$5.21	$5.37	$5.53	$5.70	$5.87
Disease Management Coaching - Diabetes					
High risk	$40.64	$41.86	$43.11	$44.41	$45.74
Moderate risk	$21.97	$22.63	$23.31	$24.01	$24.73
Low risk	$9.10	$9.37	$9.65	$9.94	$10.24
Disease Management Coaching - Congestive heart failure					
High risk	$96.70	$99.60	$102.59	$105.67	$108.84
Moderate risk	$28.41	$29.26	$30.14	$31.04	$31.97
Low risk	$18.07	$18.61	$19.17	$19.74	$20.33

Source: State of Tennessee contract with American Healthways Services, LLC.

Appendix 3
Healthways Engagement Script

Engagement Script

Hello, may I speak with **[Member's Name]**?
INTRODUCTION: Hi, my name is ____ and I am an Engagement Specialist for the ParTNers for Health Wellness Program. I'm calling today to enroll you in coaching. Members who receive this call to enroll in coaching are required to participate to maintain the Partnership PPO from the State of Tennessee in 2015. Do you have a minute to talk?
Okay, before I go into more detail, I want to let you know that our calls are monitored and recorded for quality and training purposes.
Because of HIPPA rules and regulations, I will need to verify some information --. [Collect HIPPA information from member].
Now, let's schedule your first call so you can meet your coach. Can you tell me your preferred phone number and the best day of the week and time of day you would like your coach to call you.

Thank you. I have you scheduled for [x time of day] on [x date].During your first call, your coach will share some information about coaching, help you make a plan and schedule future calls.

IF DECLINES PROGRAM:
I am removing you from our Coaching program at your request. Please note, that by not participating in coaching for 2015, you will not be eligible for the Partnership Promise during open enrollment for 2016.

So you recognize the call from your coach, we recommend that you add our phone number to your contacts under the name **Healthways Coach**. Are you able take down this number? (It's **1-888-741-3390.**)
On future calls, you will always be asked to verify your full name, date of birth and complete address …again that's to protect your privacy.

If you'd like any more information about this program, you can visit the **partnersforhealthtn.gov** website any time. You can also call us at the toll-free number I mentioned earlier**.** We are here **Monday through Friday from 8 a.m. to 8:00 p.m. Central Standard Time.**

Before I go, I do want to remind you that to maintain your Partnership Promise you will need to continue to accept your coaching calls for the remainder of the year.
Alright, do you have any other questions for me?
Great. I appreciate you taking time to speak with me. We look forward to working with you. And I hope you have a wonderful day/evening!

Questions or Concerns

"I don't know that you are really calling from my health plan, I'm not giving you any of my personal information."

- I understand you not wanting to provide your personal information. I am happy to give you our phone number so you can ensure you're speaking with a representative from the ParTNers for Health Wellness Program. That number is **1-888-741-3390.**

Any other questions asked:

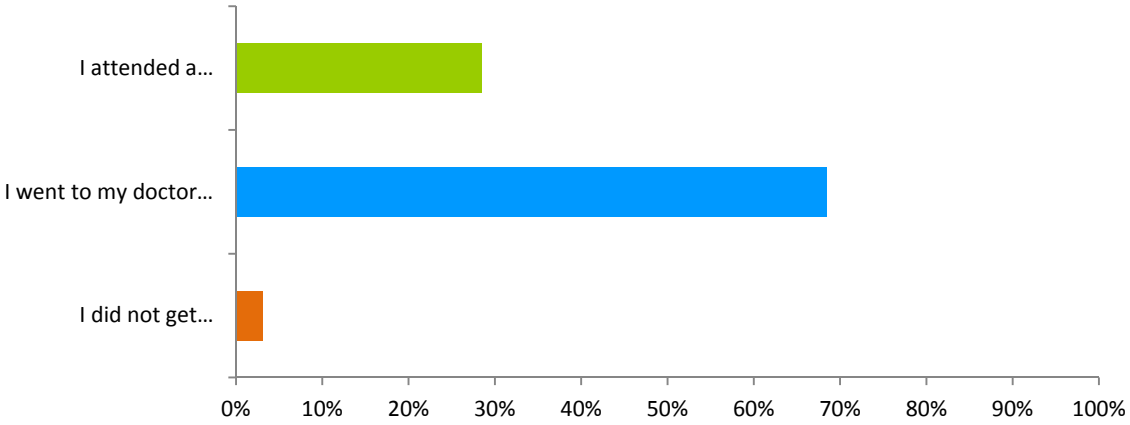
- I understand you have questions, but in my role as an Engagement Specialist I request your consent to participate, enroll you in coaching and get your preferred contact information. On your first call with your coach, you will be able to review these questions with them.

I understand you would prefer not to enroll until you have a better understanding of the coaching program. If I can get the best days and times to call I can schedule a call with a coach and the coach will reach out to you for an overview of coaching and the reason for receiving coaching calls.

Appendix 4
Wellness Program Survey

Q1: How did you get your biometric screening this year?

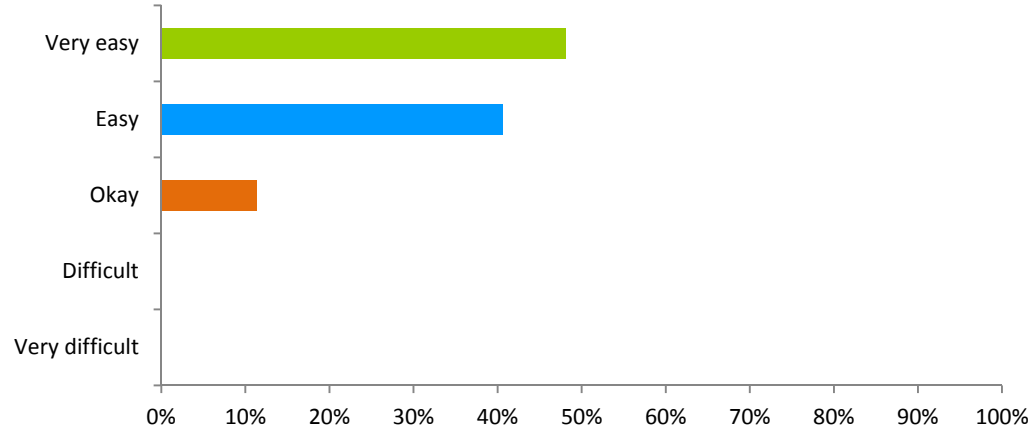
Answered: 840 Skipped: 1



Answer Choices	Responses	
I attended a workplace screening	**28.45%**	239
I went to my doctor/healthcare provider	**68.45%**	575
I did not get a biometric screening done this year	**3.10%**	26
Total		**840**

Q2: How easy was it to schedule your workplace screening?

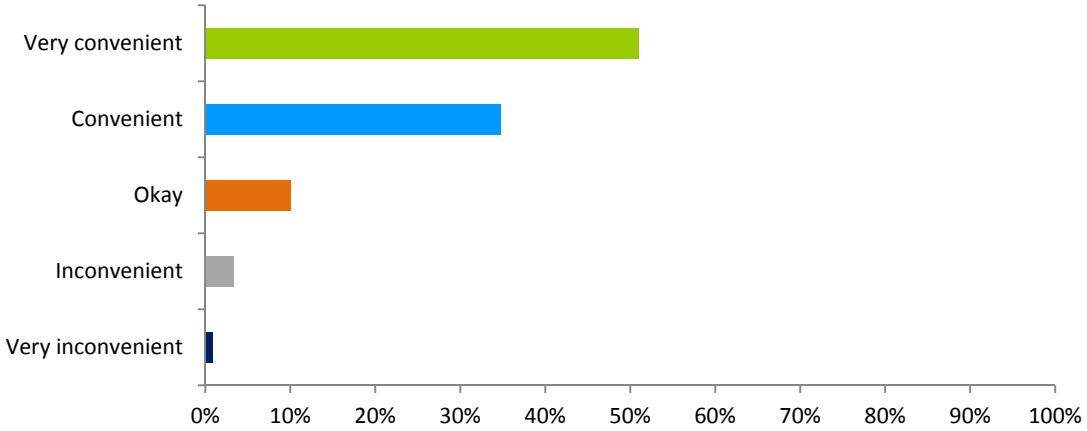
Answered: 239 Skipped: 602



Answer Choices	Responses	
Very Easy	**48.12%**	115
Easy	**40.59%**	97
Okay	**11.30%**	27
Difficult	**0.00%**	0
Very difficult	**0.00%**	0
Total		**239**

Q3: How convenient was the location of the workplace screening you attended?

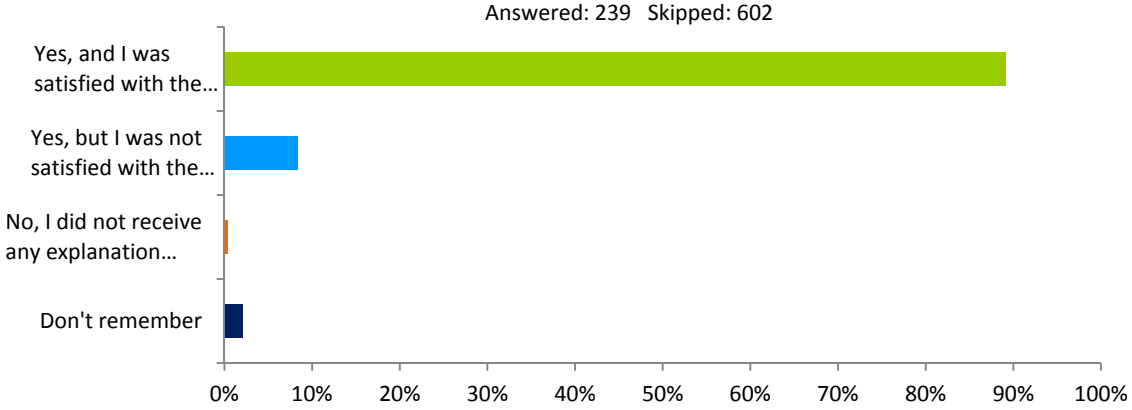
Answered: 239 Skipped: 602



Answer Choices	Responses	
Very convenient	**51.05%**	122
Convenient	**34.73%**	83
Okay	**10.04%**	24
Inconvenient	**3.35%**	8
Very inconvenient	**0.84%**	2
Total		**239**

Q4: Did you receive an explanation of your benefits after completing the workplace screening?

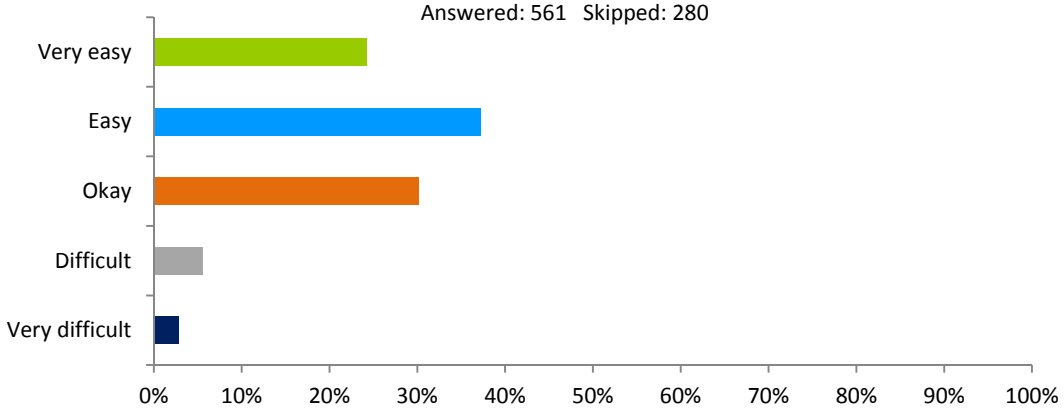
Answered: 239 Skipped: 602



Answer Choices	Responses	
Yes, and I was satisfied with the explanation	**89.12%**	213
Yes, but I was not satisfied with the explanation	**8.37%**	20
No, I did not receive any explanation after the workplace screening	**0.42%**	1
Don’t remember	**2.09%**	5
Total		**239**

Q5: How easy was it to download the physician screening form (the form required for the biometric screening) you needed for your doctor/healthcare provider?

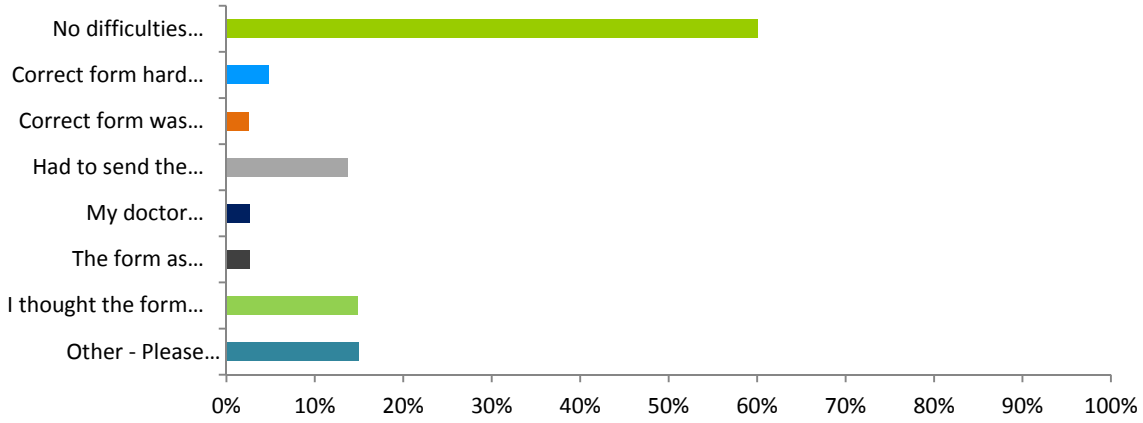
Answered: 561 Skipped: 280



Answer Choices	Responses	
Very easy	**24.24%**	136
Easy	**37.25%**	209
Okay	**30.12%**	169
Difficult	**5.53%**	31
Very difficult	**2.85%**	16
Total		**561**

Q6: Did you or your provider have any difficulties with submitting your biometric screening? Check all that apply.

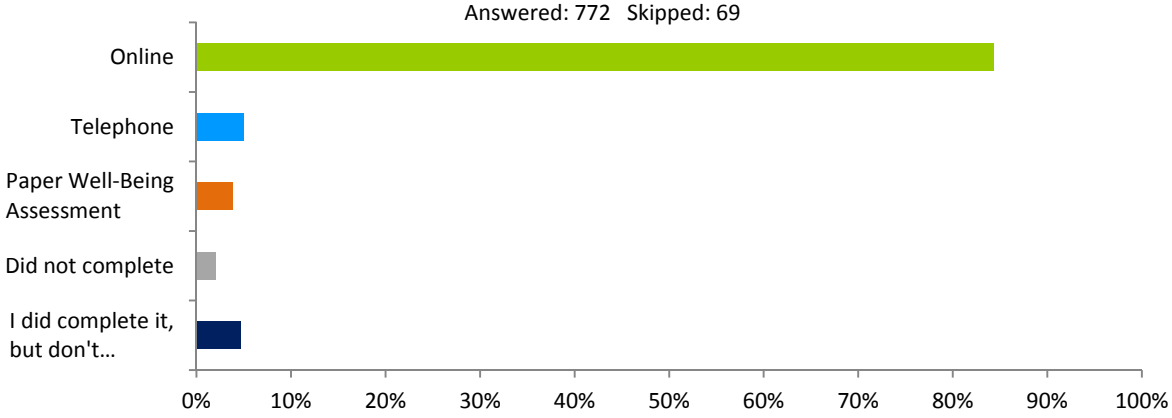
Answered: 559 Skipped: 282



Answer Choices	Responses	
No difficulties submitting this year's biometric screening	**60.11%**	336
Correct form hard to locate on the website	**4.83%**	27
Correct form was difficult to obtain	**2.50%**	14
Had to send the form multiple times	**13.77%**	77
My doctor neglected to submit the form	**2.68%**	15
The form as submitted was not complete	**2.68%**	15
I thought the form was properly received, but I was informed that it was not	**14.85%**	83
Other - Please explain	**15.03%**	84
Total		**559**

Q7: Which of the following methods did you use to complete your Well-Being Assessment (WBA/health questionnaire) in 2014?

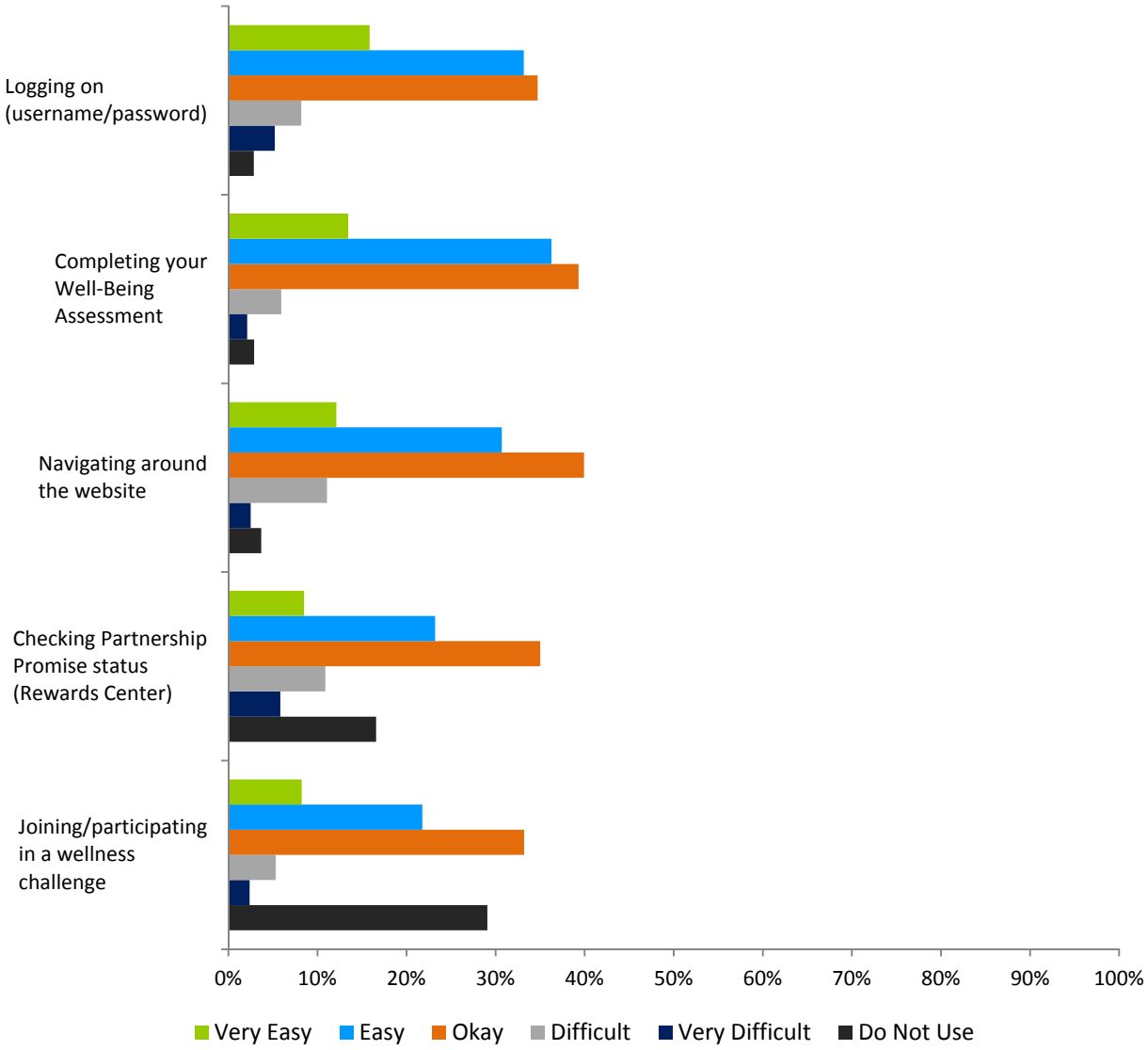
Answered: 772 Skipped: 69



Answer Choices	Responses	
Online	**84.33%**	651
Telephone	**5.05%**	39
Paper Well-Being Assessment	**3.89%**	30
Did not complete	**2.07%**	16
I did complete it, but don't remember by which method	**4.66%**	36
Total		**772**

Q8: How would you rate the ease of use of the following aspects of the Well-Being Connect website?

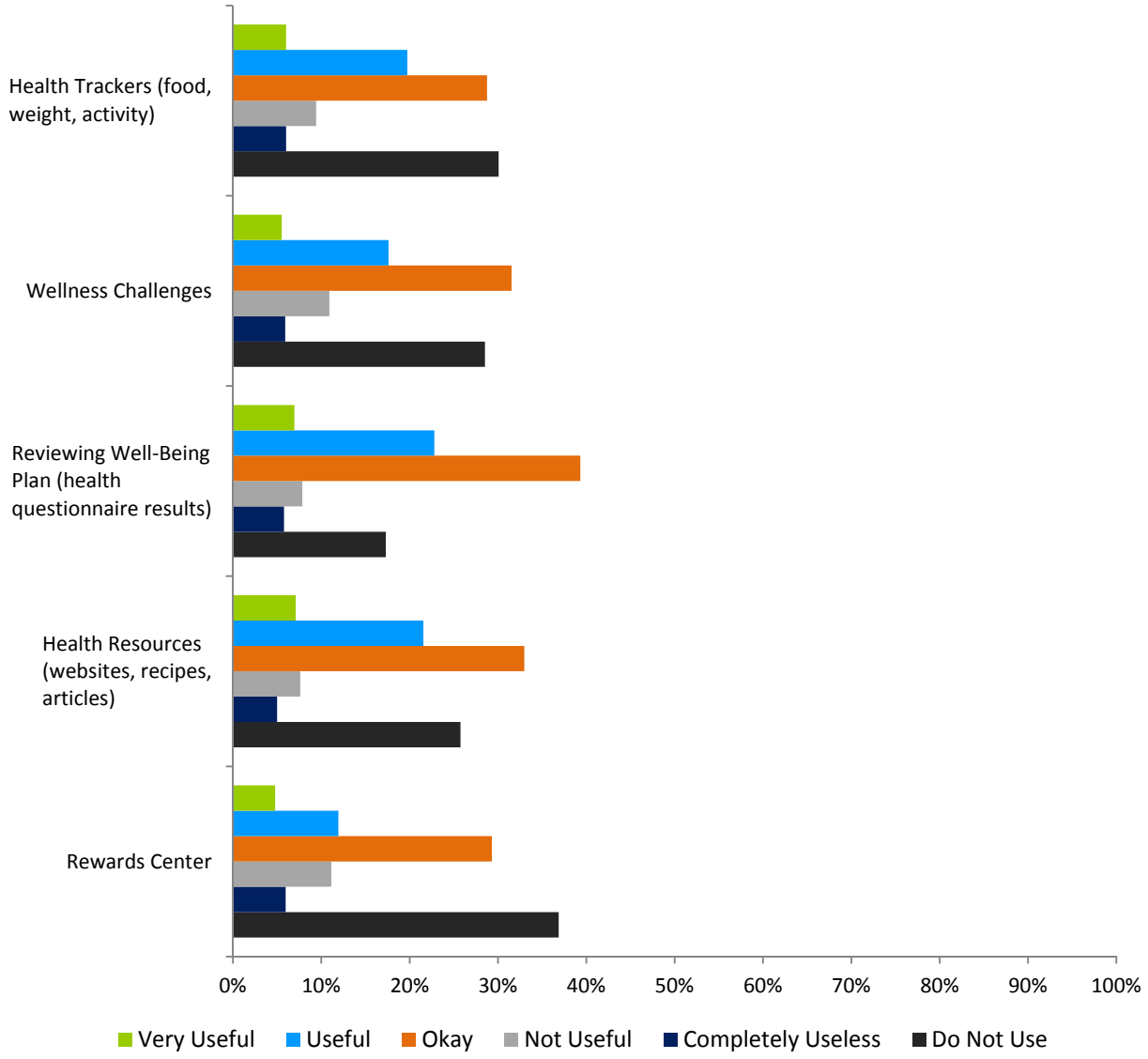
Answered: 770 Skipped: 71



	Very Easy	Easy	Okay	Difficult	Very Difficult	Do Not Use	Total
Logging on (username/password)	**15.86%** 122	**33.16%** 255	**34.72%** 267	**8.19%** 63	**5.20%** 40	**2.86%** 22	769
Completing your Well-Being Assessment	**13.46%** 102	**36.28%** 275	**39.31%** 298	**5.94%** 45	**2.11%** 16	**2.90%** 22	758
Navigating around the website	**12.12%** 92	**30.70%** 233	**39.92%** 303	**11.07%** 84	**2.50%** 19	**3.69%** 28	759
Checking Partnership Promise status (Rewards Center)	**8.49%** 64	**23.21%** 175	**35.01%** 264	**10.88%** 82	**5.84%** 44	**16.58%** 125	754
Joining/participating in a wellness challenge	**8.23%** 62	**21.78%** 164	**33.20%** 250	**5.31%** 40	**2.39%** 18	**29.08%** 219	753

Q9: How would you rate the usefulness of the following resources on the Well-Being Connect website?

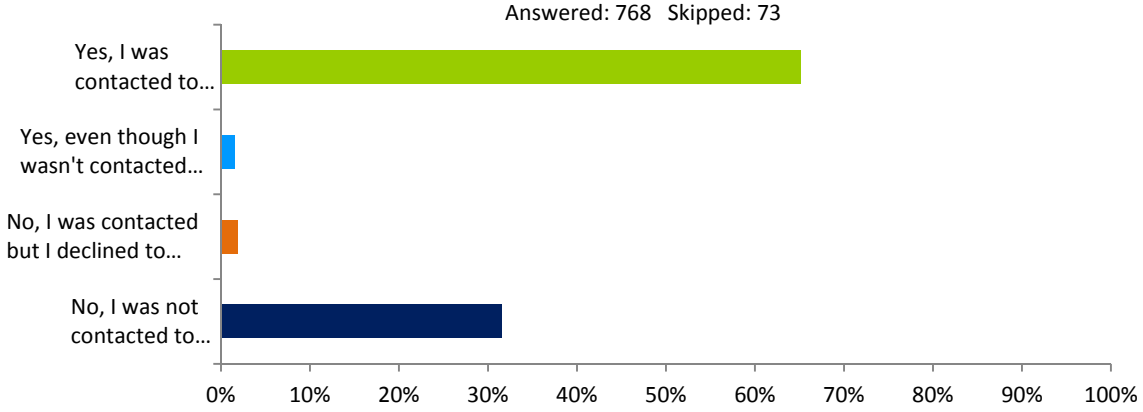
Answered: 767 Skipped: 74



	Very Useful	Useful	Okay	Not Useful	Completely Useless	Do Not Use	Total
Health Trackers (food, weight, activity)	**6.01%** 46	**19.74%** 151	**28.76%** 220	**9.41%** 72	**6.01%** 46	**30.07%** 230	765
Wellness Challenges	**5.52%** 42	**17.61%** 134	**31.54%** 240	**10.91%** 83	**5.91%** 45	**28.52%** 217	761
Reviewing Well-Being Plan (health questionnaire results)	**6.95%** 53	**22.80%** 174	**39.32%** 300	**7.86%** 60	**5.77%** 44	**17.30%** 132	763
Health Resources (websites, recipes, articles)	**7.10%** 54	**21.55%** 164	**32.98%** 251	**7.62%** 58	**4.99%** 38	**25.76%** 196	761
Rewards Center	**4.77%** 36	**11.94%** 90	**29.31%** 221	**11.14%** 84	**5.97%** 45	**36.87%** 278	754

Q10: During the past 12 months, have you participated in the Healthways health coaching program?

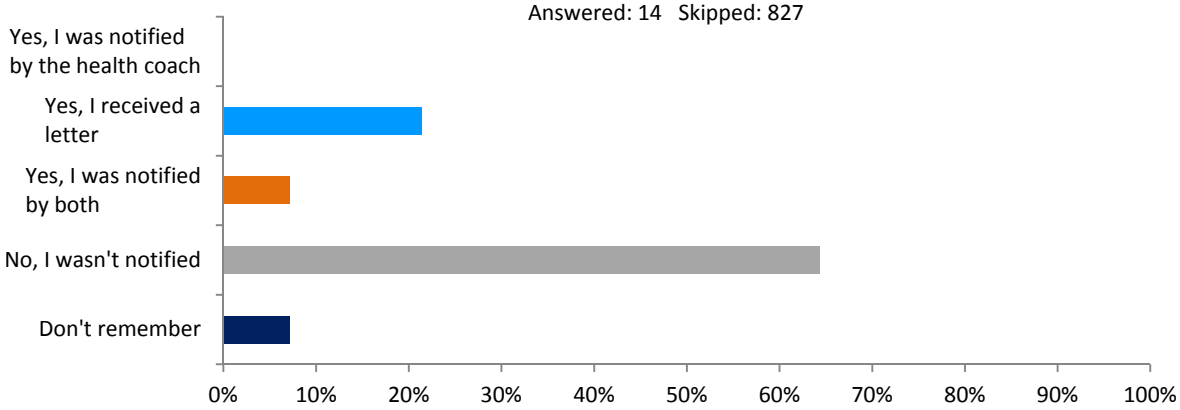
Answered: 768 Skipped: 73



Answer Choices	Responses	
Yes, I was contacted to participate in coaching	**65.10%**	500
Yes, even though I wasn't contacted I chose to participate in coaching	**1.56%**	12
No, I was contacted but I declined to participate	**1.82%**	14
No, I was not contacted to participate	**31.51%**	242
Total		**768**

Q11: When you declined to participate in health coaching were you notified you would be transferred to the standard plan?

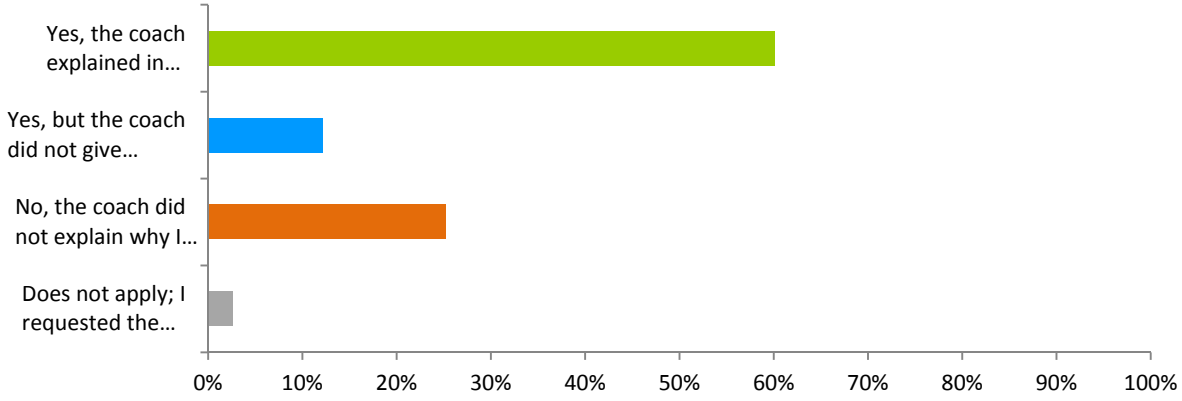
Answered: 14 Skipped: 827



Answer Choices	Responses	
Yes, I was notified by the health coach	**0.00%**	0
Yes, I received a letter	**21.43%**	3
Yes, I was notified by both	**7.14%**	1
No, I wasn't notified	**64.29%**	9
Don't remember	**7.14%**	1
Total		**14**

Q12: Were you given an explanation of why you were chosen for coaching?

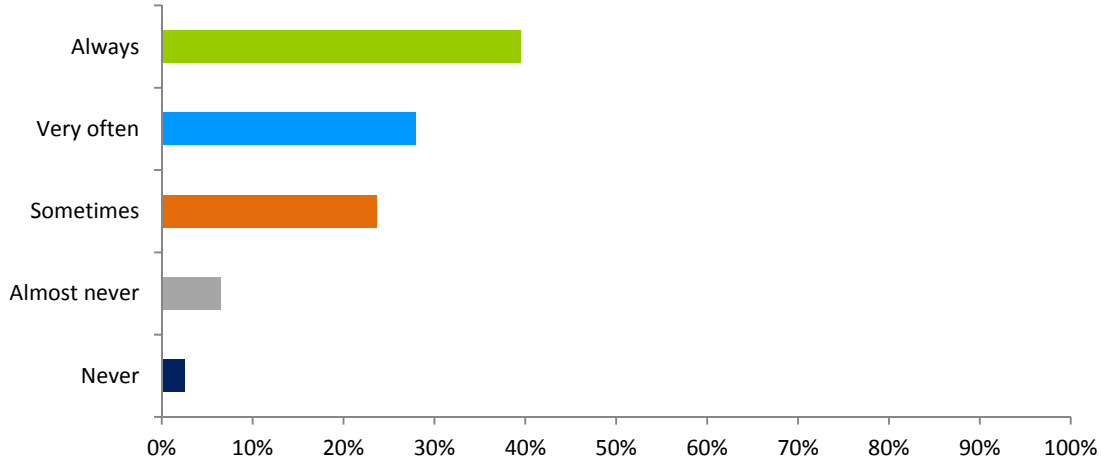
Answered: 504 Skipped: 337



Answer Choices	Responses	
Yes, the coach explained in detail to my satisfaction	**60.12%**	303
Yes, but the coach did not give enough detail to my satisfaction	**12.10%**	61
No, the coach did not explain why I was selected for coaching	**25.20%**	127
Does not apply; I requested the coaching	**2.58%**	13
Total		**504**

Q13: Did your coach call you as scheduled?

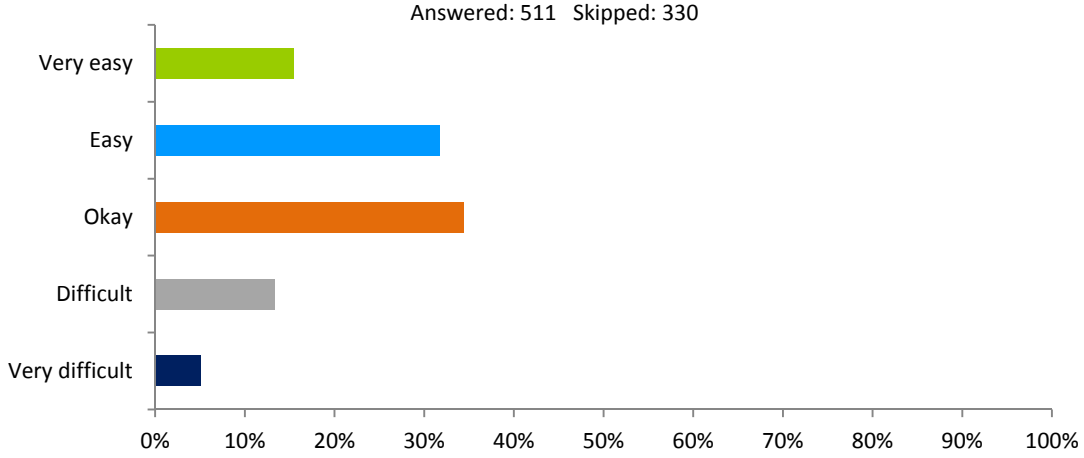
Answered: 512 Skipped: 329



Answer Choices	Responses	
Always	**39.45%**	202
Very often	**27.93%**	143
Sometimes	**23.63%**	121
Almost never	**6.45%**	33
Never	**2.54%**	13
Total		**512**

Q14: How easy was it to connect with your coach and receive your coaching calls?

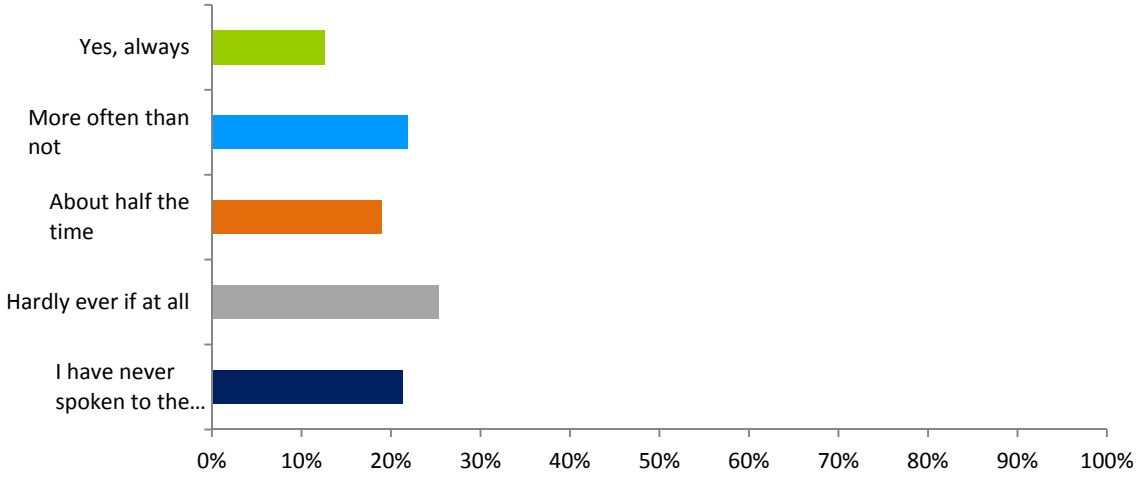
Answered: 511 Skipped: 330



Answer Choices	Responses	
Very easy	**15.46%**	79
Easy	**31.70%**	162
Okay	**34.44%**	176
Difficult	**13.31%**	68
Very difficult	**5.09%**	26
Total		**511**

Q15: Do you speak to the same coach each time?

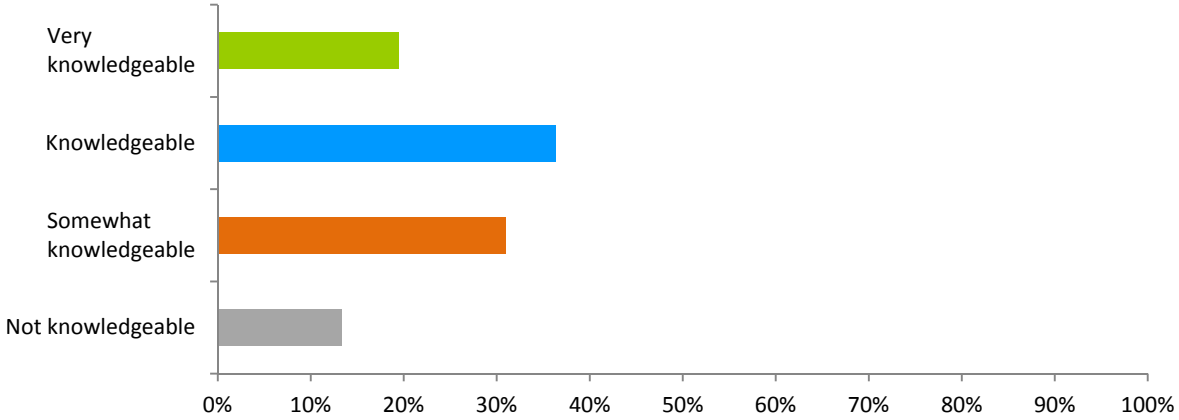
Answered: 502 Skipped: 339



Answer Choices	Responses	
Yes, always	**12.55%**	63
More often than not	**21.91%**	110
About half the time	**18.92%**	95
Hardly ever if at all	**25.30%**	127
I have never spoken to the same coach more than once	**21.31%**	107
Total		**502**

Q16: Overall, how knowledgeable would you say your coach was about your health condition(s)?

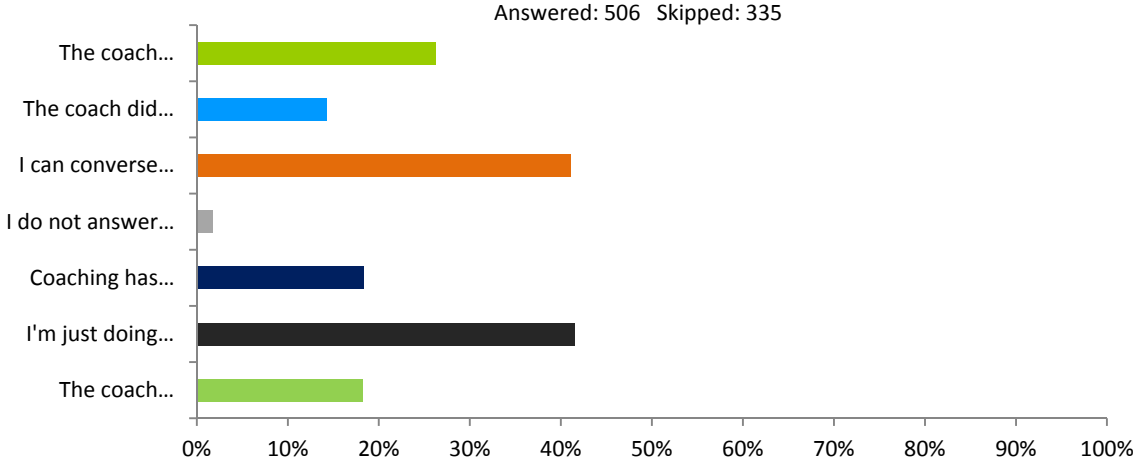
Answered: 504 Skipped: 337



Answer Choices	Responses	
Very knowledgeable	**19.44%**	98
Knowledgeable	**36.31%**	183
Somewhat knowledgeable	**30.95%**	156
Not knowledgeable	**13.29%**	67
Total		**504**

Q17: How would you describe your coaching experience? Check all that apply.

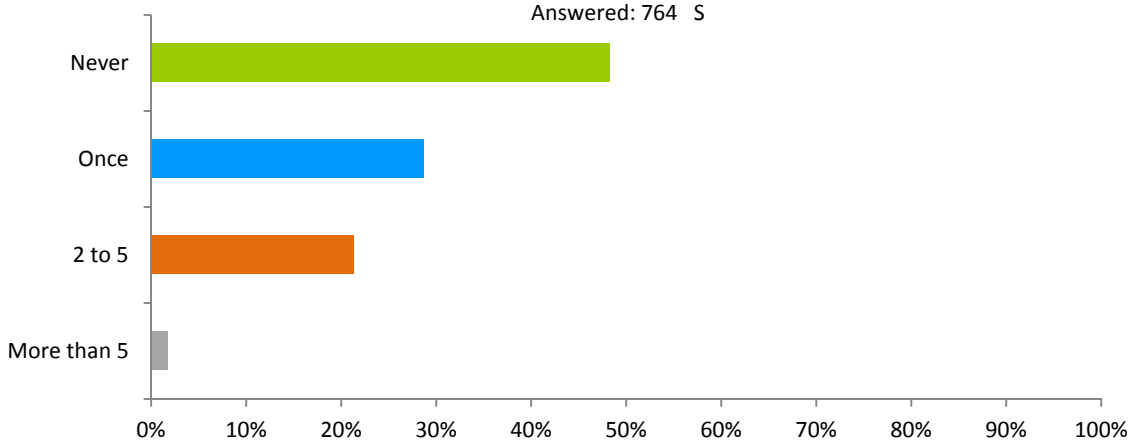
Answered: 506 Skipped: 335



Answer Choices	Responses	
The coach motivates me and has influenced me to change	**26.28%**	133
The coach did not provide meaningful or useful information and suggestions	**14.23%**	72
I can converse and speak candidly with my coach	**41.11%**	208
I do not answer the coach's questions truthfully	**1.78%**	9
Coaching has helped me improve my health	**18.38%**	93
I'm just doing this to satisfy my requirements	**41.50%**	210
The coach has not motivated or influenced me to change	**18.18%**	92
Total		**506**

Q18: During the past 12 months how many times have you called the Healthways customer service representatives (for example, to get help with username/password, check on your Partnership Promise status, complete your Well-Being Assessment?

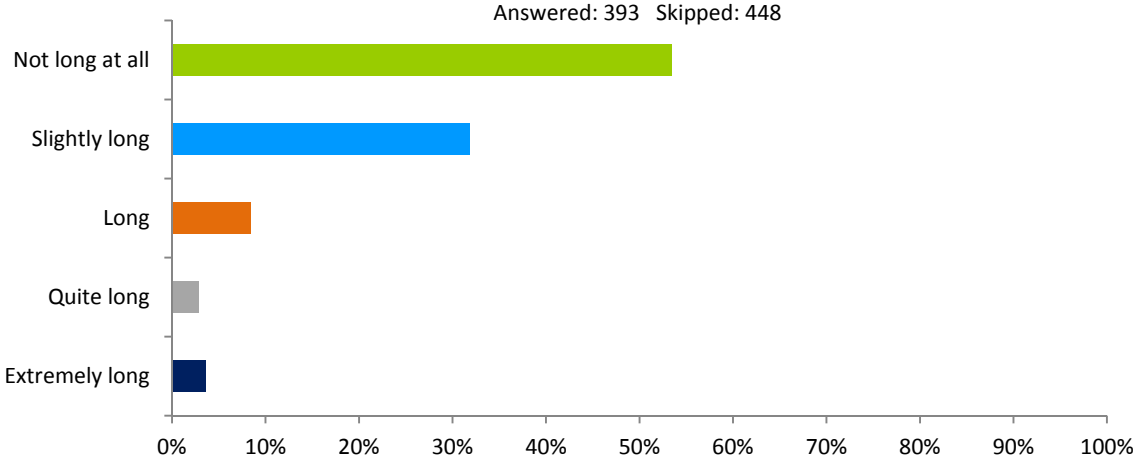
Answered: 764 S



Answer Choices	Responses	
Never	**48.30%**	369
Once	**28.66%**	219
2 to 5	**21.34%**	163
More than 5	**1.70%**	13
Total		**764**

Q19: Typically, how long was your hold time before you could speak to a Healthways customer service representative?

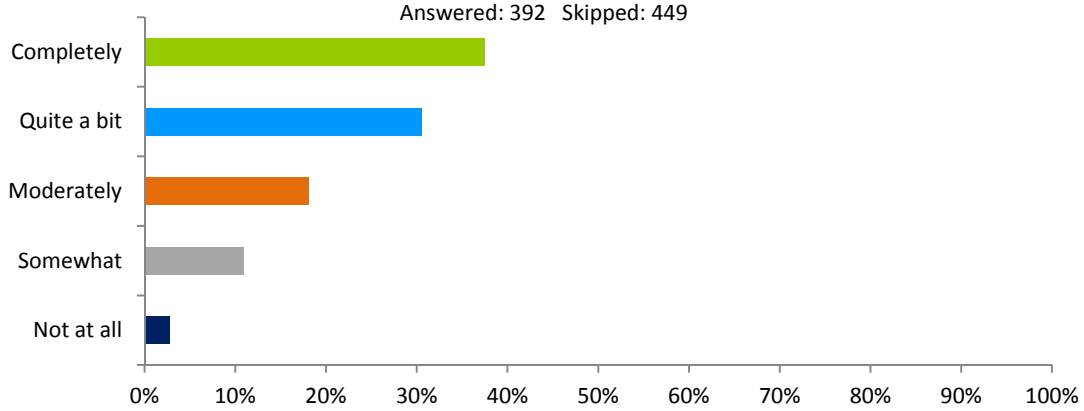
Answered: 393 Skipped: 448



Answer Choices	Responses	
Not long at all	**53.44%**	210
Slightly long	**31.81%**	125
Long	**8.40%**	33
Quite long	**2.80%**	11
Extremely long	**3.56%**	14
Total		**393**

Q20: Generally, how well were the customer service representatives able to help you with your issues or answer your question?

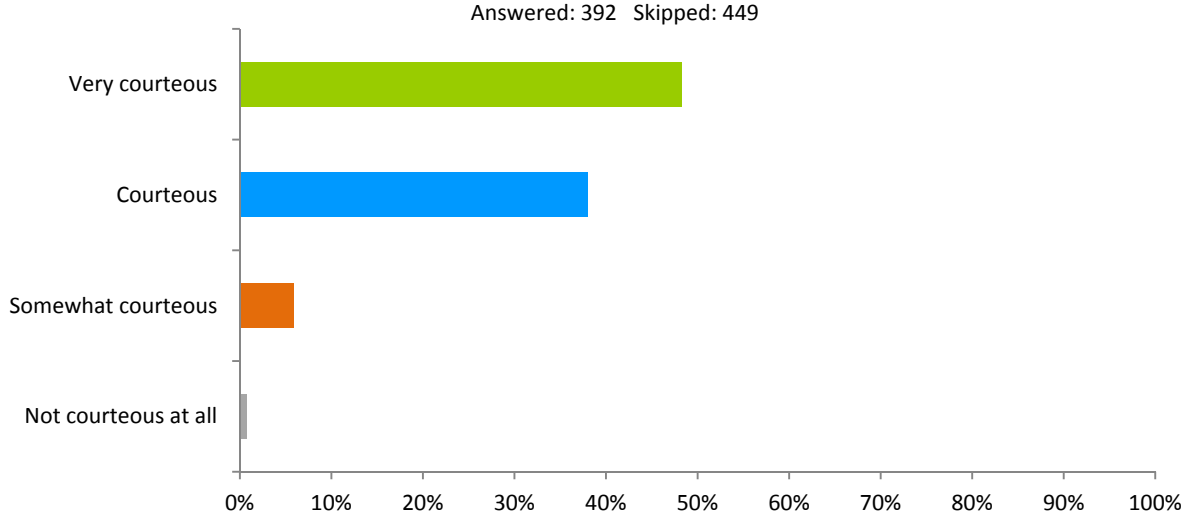
Answered: 392 Skipped: 449



Answer Choices	Responses	
Completely	**37.50%**	147
Quite a bit	**30.61%**	120
Moderately	**18.11%**	71
Somewhat	**10.97%**	43
Not at all	**2.81%**	11
Total		**392**

Q21: As a rule, how courteous were the customer service representatives?

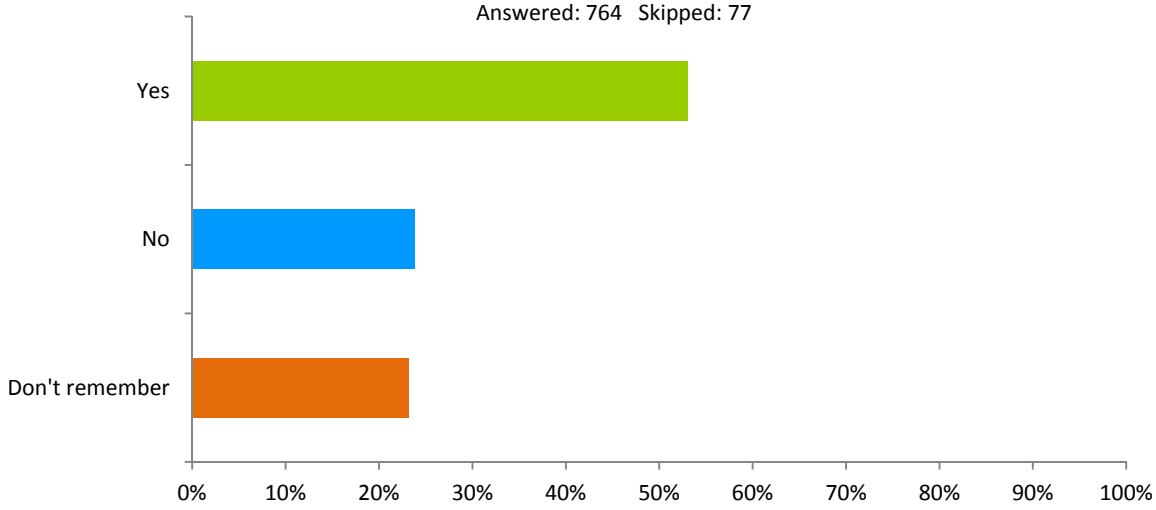
Answered: 392 Skipped: 449



Answer Choices	Responses	
Very courteous	**55.36%**	217
Courteous	**38.01%**	149
Somewhat courteous	**5.87%**	23
Not courteous at all	**0.77%**	3
Total		**392**

Q22: Did you receive timely confirmation of your Partnership Promise completion status in 2014?

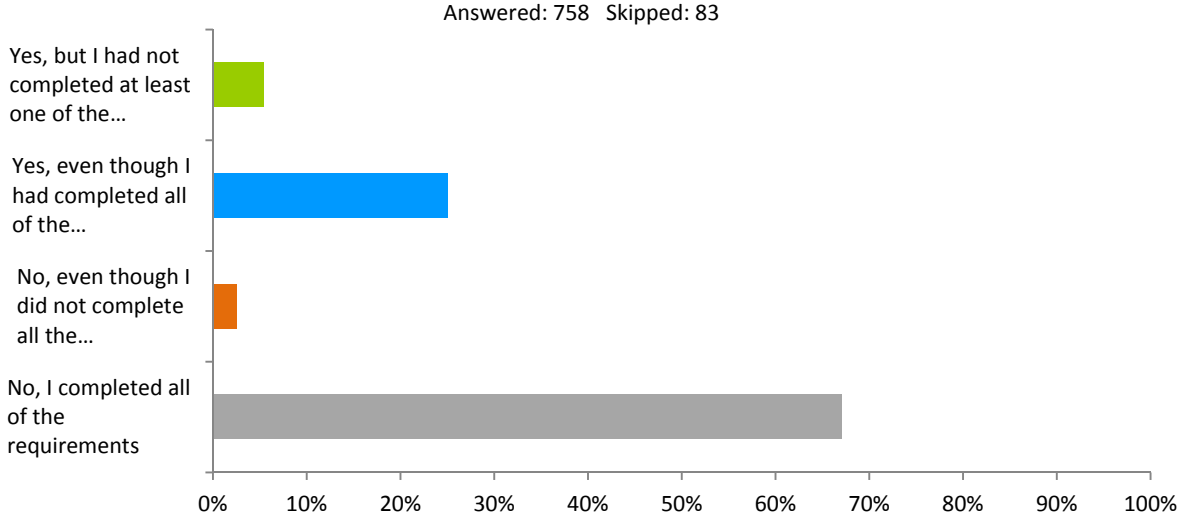
Answered: 764 Skipped: 77



Answer Choices	Responses	
Yes	**53.01%**	405
No	**23.82%**	182
Don't remember	**23.17%**	177
Total		**764**

Q23: Did you receive a letter of non-compliance from Healthways?

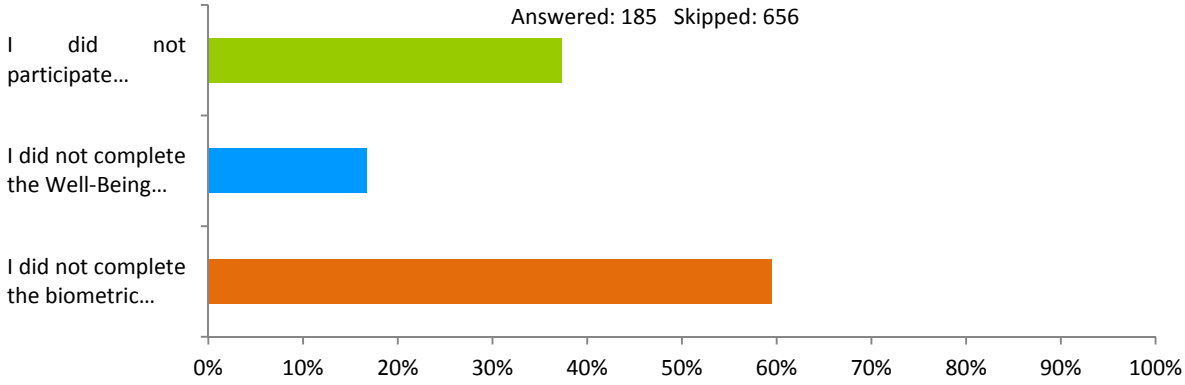
Answered: 758 Skipped: 83



Answer Choices	Responses	
Yes, but I had not completed at least one of the requirements	**5.41%**	41
Yes, even though I had completed all of the requirements	**25.07%**	190
No, even though I did not complete all the requirements	**2.51%**	19
No, I completed all of the requirements	**67.02%**	508
Total		**758**

Q24: What reason did the letter give for your non-compliance? Check all that apply.

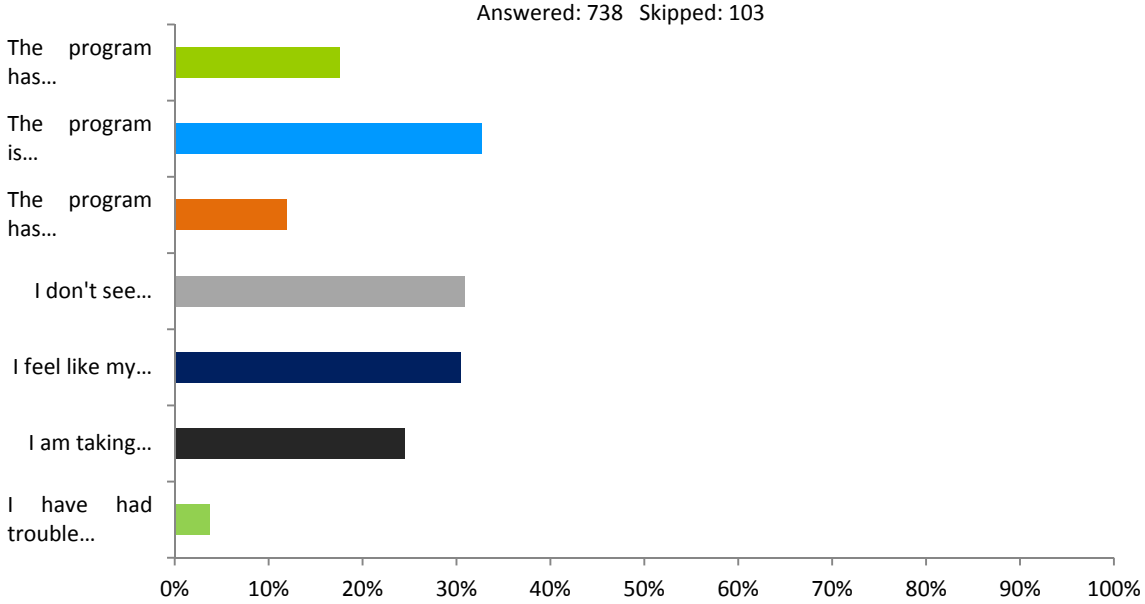
Answered: 185 Skipped: 656



Answer Choices	Responses	
I did not participate in coaching	**37.30%**	69
I did not complete the Well-Being Assessment	**16.76%**	31
I did not complete the biometric screening	**59.46%**	110
Total		**185**

Q25: How would you describe your overall experience with the wellness program? Check all that apply.

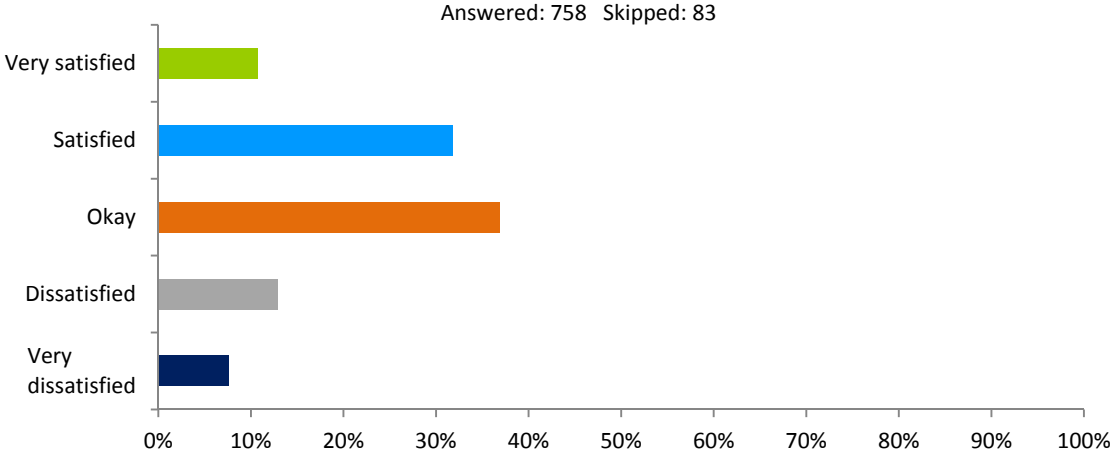
Answered: 738 Skipped: 103



Answer Choices	Responses	
The program has helped me improve my lifestyle	**17.62%**	130
The program is good for those who need it	**32.66%**	241
The program has influenced me to see my doctor	**11.92%**	88
I don't see the benefit for myself personally	**30.89%**	228
I feel like my health is good and I just do what I'm asked to	**30.49%**	225
I am taking new steps to improve my health	**24.53%**	181
I have had trouble completing the requirements of the Partnership Promise	**3.79%**	28
Total		**738**

Q26: Thinking about all of your interactions with the wellness program, how satisfied are you?

Answered: 758 Skipped: 83



Answer Choices	Responses	
Very satisfied	**10.69%**	81
Satisfied	**31.79%**	241
Okay	**36.94%**	280
Dissatisfied	**12.93%**	98
Very dissatisfied	**7.65%**	58
Total		**758**

Appendix 5
Direct Appropriations
Fiscal Years 2013-2016

State Pass-through Agency	Description	Direct Appropriation Amount			
		2013	2014	2015	2016
Agriculture, Department of	Future Farmers of America (non-recurring grant, earmarked from Market Development)	$250,000	$250,000	$250,000	
	4-H Foundation (non-recurring grant, earmarked from Market Development)	250,000	250,000	250,000	
Arts Commission	Fisk University - Stieglitz Collection Maintenance	80,000	80,000	80,000	80,000
	Tennessee Performing Arts Center Management Corporation - Educational Opportunities	100,000	100,000	100,000	100,000
	Africa in April Cultural Awareness Festival, Inc.	45,000	45,000	45,000	45,000
Children's Services	National Institute for Law and Equity (NILE) - Operational Expenses and programs, including Parent Partner Program (non-recurring)	95,000			
	Tennessee CASA (non-recurring)	10,000			
	Grant of $2,000 to each of the Tennessee Child Advocacy Centers		64,000		
	A Secret Safe Place for Newborns of Tennessee, Inc. - Safe Haven Law (non-recurring)	49,000	49,000	49,000	49,000
Commission on Children and Youth	Grant of $1,500 to each of the 44 Court Appointed Special Advocates (CASA) - operational expenses		66,000		
	Tennessee Court Appointed Advocates (CASA) Association - maintain current staffing levels		25,000		
Correction, Department of	Project Return	182,000	182,000	182,000	182,000
	Dismas, Inc. - From these funds, $25,000 is earmarked for Chattanooga Endeavors and $8,000 is earmarked for Better Decisions for program operations	136,500	136,500	136,500	136,500
	Big Brothers Big Sisters - Amachi Mentoring for Children of Inmates (non-recurring)	250,000	250,000	250,000	250,000
	Operation Safe Community in Shelby County - Year 2 of 2 - For training, database management, and one position (non-recurring)	110,000			
Economic and Community Development, Department of	Nashville Minority Business Center	100,000	100,000	100,000	100,000
	Minority Enterprise Development	100,000	100,000	100,000	100,000
	Nine Development Districts Grants at $50,000 each - local planning transition grants (non-recurring)	450,000	450,000		450,000
	Carroll County Lake – grant to Carroll County Watershed Authority		5,000,000		
	Legacy Parks Foundation in Knoxville - economic development grant - Match city and county funds (non-recurring)		30,000		
	Mississippi River Corridor				50,000

Education, Department of	Tennessee History for Kids, Inc. - Operational Expenses (non-recurring)	100,000	100,000	100,000	100,000
	Tennessee Alliance of Boys & Girls Clubs - Career and technical education programming (non-recurring)	105,000	125,000	125,000	125,000
	Save the Children - Literacy Programs (non-recurring)	1,000,000	1,000,000	1,000,000	1,000,000
	Arts Academy			200,000	200,000
	Public Television Stations		125,000	2,786,800	2,786,800
	Family Resource Centers			3,050,000	3,050,000
	Little Tennessee Valley Educational Cooperative		50,000		
Environment and Conservation, Department of	Chickasaw Basin Authority (non-recurring)	100,000	100,000		
	Stax Museum			100,000	
	Alex Haley House			50,000	
Finance and Administration, Department of	Tennessee Association of Rescue Squads	71,300	71,300	71,300	71,300
	YMCA Youth Legislature	25,000	25,000	25,000	25,000
	YMCA Community Action Program	350,000	350,000	350,000	350,000
	Forensic Center at Quillen College of Medicine	100,000	100,000	100,000	100,000
	University of Tennessee Center for Business and Economic Research - Research assistance	159,200	159,200	159,200	159,200
	University of Tennessee Center for Business and Economic Research - State Census Data Center services under contract with U. S. Census Bureau	278,000	278,000	278,000	278,000
	Civil Rights Museum	250,000	250,000	250,000	250,000
	Civil Rights Museum – structural improvements		350,000		
	American Battle Monuments Commission - Maintenance of World War I monuments in France	13,500	3,500	3,500	3,500
	Tennessee Coalition Against Domestic and Sexual Violence to support the activities of the Tommy Burks Victim Assistance Academy. Funded by interdepartmental revenue from Criminal Injuries Compensation Fund	100,000	100,000	100,000	100,000
	Memphis Area Legal Services, West Tennessee Legal Services, Legal Aid of East Tennessee, and Legal Aid Society of Middle Tennessee and the Cumberlands for training and education.	700,000			
	Rutherford County Drug Court (37,500) and Williamson County Drug Court (37,500) - Operational Expenses (non-recurring)	75,000			
	Shelby County Drug Court - Programs, services, and operational expenses (non-recurring)	100,000			
	Nashville Drug Court Support Foundation - General operating costs relative to substance abuse prevention and issue resolution (non-recurring)	100,000			

	A Bridge of Hope - Law enforcement officer training on human trafficking (non-recurring)	100,000			
	Tennessee Association of Rescue Squads - Underwater radar and associated costs (non-recurring)	125,000			
	Tennessee Association of Rescue Squads - Operational costs (non-recurring)	15,000			
	National Black Caucus of State Legislators - Memphis Meeting (non-recurring)		100,000		
	Grants of $200,000 to each of the four accredited Tennessee zoos and the Tennessee Aquarium to be used for capital improvement programs (non-recurring)		1,000,000		1,000,000
	James K. Polk Memorial Association - renovation and improvement (non-recurring)		150,000		
	Academy for Youth Empowerment in Shelby County - Regional activities (non-recurring)		95,000		
	Grant of $5,000 to each of the four Tennessee National Coalition of 100 Black Women (non-recurring)		20,000		
	YMCA Community Action Project (Y-CAP) - Equal amounts from the sum provided to the YMCA organizations in Memphis, Nashville, Knoxville, and Chattanooga (non-recurring)		48,000		
	Watkins College of Art, Design, and Film-Maintenance and Repairs (non-recurring)				300,000
	City of Oak Ridge – completion improvements to rowing facility				250,000
Health, Department of	St. Jude Hospital for patient and family travel assistance	263,700	263,700	263,700	263,700
	Comprehensive Sickle Cell Clinic of Memphis Methodist Healthcare (non-recurring)	50,000	50,000	50,000	50,000
	Nonprofit organization for promotion of health awareness among Tennessee males	50,000	50,000	50,000	50,000
	The Crumley House in Washington County - programs and services on behalf of persons suffering from traumatic brain injuries (non-recurring)	100,000	100,000	100,000	100,000
	Sickle Cell Foundation of Tennessee (non-recurring)	75,000	75,000	75,000	75,000
	Memphis Oral School for the Deaf - programs and operations (non-recurring)	125,000			
	Meharry Medical College - Meharry HBCU Wellness Project (non-recurring)	800,000			
	Diggs-Kraus Sickle Cell Center - research and services (non-recurring)		10,000		

	Epilepsy Foundation of Middle and West TN at $63,000; Epilepsy Foundation of Southwest TN at $11,300; Epilepsy Foundation of East TN at $28,300 (non-recurring)				102,600
	Andrew Jackson Foundation – Restoration of windows at Hermitage Mansion (non-recurring)				154,400
	Historic Sam Davis Home and Plantation – roofing repairs (non-recurring)				9,300
Higher Education	Western Governors University		5,000,000		
Historical Commission	City of Parkers Crossroads - Parkers Crossroads Battlefield Interpretation	109,000			
	Stax Museum in Memphis		100,000		100,000
	Alex Haley House and Museum		50,000		
Human Services, Department of	Second Harvest Food Bank of Tennessee - From these funds, amounts are earmarked for Second Harvest Food Bank of Middle Tennessee, Memphis Food Bank, Second Harvest Food Bank of East Tennessee, Chattanooga Area Food Bank, and Second Harvest Food Bank of Northeast Tennessee (non-recurring)	316,000	500,000		250,000
Mental Health	Not Alone, Inc. counseling services for veterans and their families		400,000	400,000	400,000
	Grant of $372,500 to each of the five community alcohol and drug services providers of adolescent residential treatment services (non-recurring)		1,862,500		1,862,500
Tourist Development, Department of	National Council for the Traditional Arts - National Folk Festival	50,000			
	NCAA Women's Basketball Final Four		100,000		
Treasury	Criminal Injuries Compensation Fund – District Attorney's General Conference for domestic violence prevention and drug enforcement authorized by *Tennessee Code Annotated*, Section 29-13-116	249,900	256,100	263,400	270,400
Veterans Affairs, Department of	West Tennessee Veterans Home, Inc. (non-recurring)		50,000		
TOTALS BY YEAR		$8,263,100	$20,644,800	$11,493,400	$15,379,200

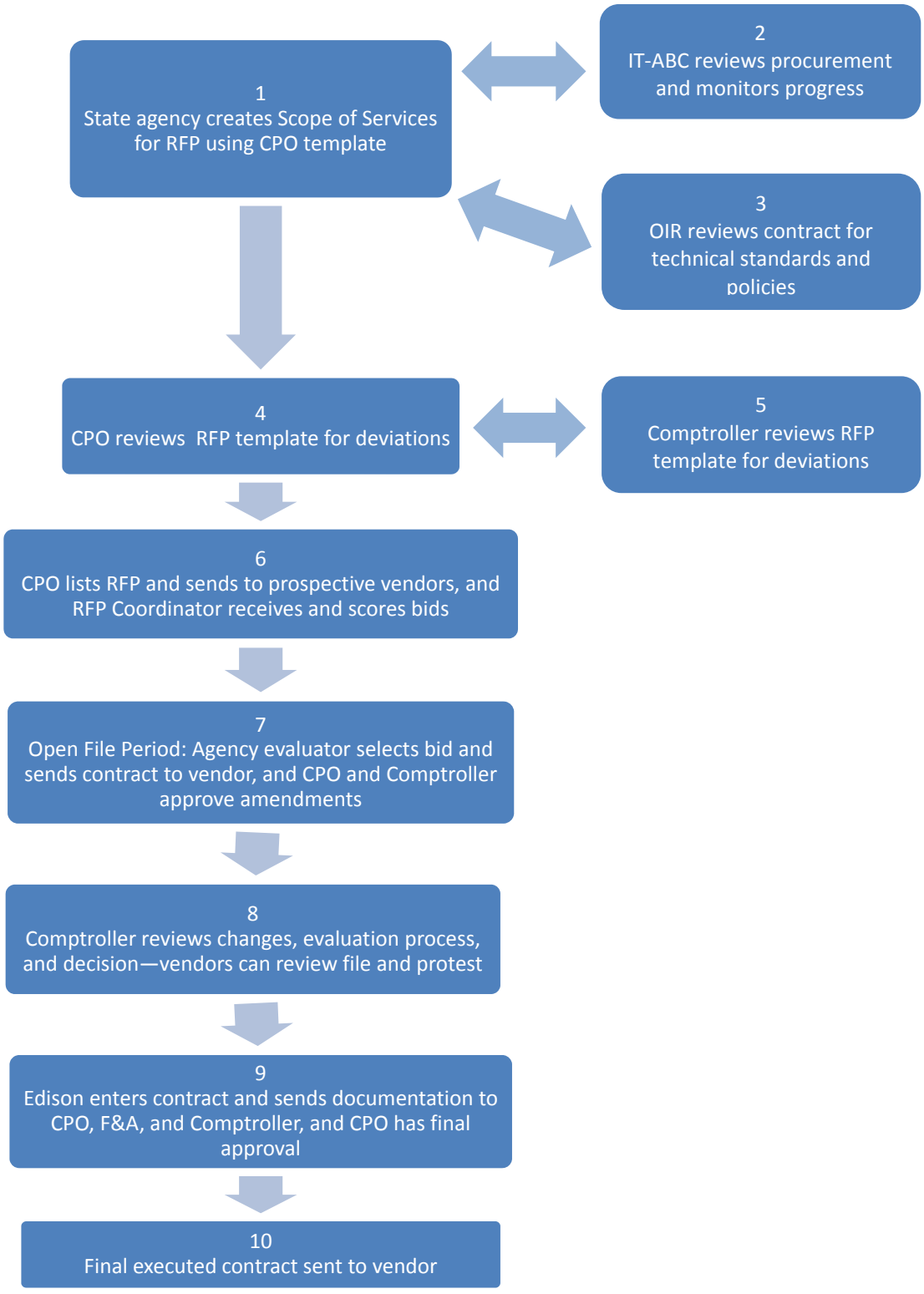
Appendix 6
Out-of-state Travel and Expense Reimbursements Reported on State Website
January – December, 2014, and January – June, 2015

Agency and Cabinet Member	Transportation		Lodging		Meals and Incidentals		Other	
	2014	2015	2014	2015	2014	2015	2014	2015
Agriculture, Commissioner	$0.00*	$0.00 *	$2,325.55	$2,193.04	$589.00	$942.5	$437.78	$284.59
Correction, Commissioner	14.00	264.19	1515.11	823.92	513.00	319.50	58.33	96.00
Economic and Community Development, Commissioner	9,921.00	0.00*	7,454.90	0.00	2,961.75	0.00	1,422.78	0.00
Education, Commissioner	318.42	0.00*	322.73	0.00	539.00	0.00	8.00	0.00
Environment and Conservation, Commissioner	1,798.66	477.50	1,223.48	308.01	752.75	705.75	767.83	41.56
Financial Institutions, Commissioner	514.60	400.37	4,438.93	3,536.26	1,384.50	835.50	0.00	0.00
General Services, Commissioner	0.00*	0.00*	1,939.36	508.42	568.00	274.18	144.20	296.35
Health, Commissioner	90.60	570.36	269.67	173.25	388.50	190.50	16.00	28.00
Human Resources, Commissioner	245.43	130.31	1,181.96	366.40	474.50	177.50	0.00	0.00
Human Services, Commissioner	457.17	70.18	1,263.68	0.00	875.00	497.00	174.00	86.00
Labor and Workforce Development, Commissioner	0.00*	0.00	823.38	0.00	909.00	0.00	158.07	0.00
Mental Health and Substance Abuse Services, Commissioner	0.00*	54.00	1,034.44	0.00	413.00	140.00	988.54	39.00
Military, Adjunct General	343.59	0.00	2,017.88	681.53	913.00	254.00	632.12	350.00
Revenue, Commissioner	405.50	0.00	614.49	0.00	263.00	0.00	101.00	0.00
Safety and Homeland Security, Commissioner	1,676.00	0.00	885.02	0.00	111.00	0.00	350.00	0.00
Tourist Development, Commissioner	2,171.13	155.00	6,137.86	359.66	1,820.75	115.00	0.00	0.00
Transportation, Commissioner	0.00*	97.70	2,880.56	1340.38	1,413.50	384.50	167.00	28.00
Veterans Affairs, Commissioner	167.01	0.00	1,714.51	631.62	754.00	248.50	327.32	39.90
Governor's Office, Chief of Staff	180.81	164.60	529.00	1,161.89	46.67	48.97	101.00	220.24
Governor's Office, Director of Communications	122.55	0.00	0.00	0.00	0.00	15.04	19.00	25.39
Total Reimbursements Reported	18,426.47	2384.21	$38,572.51	$12,084.38	$15,689.92	$5148.44	$5,872.97	$1535.03

* Indicates direct pay

Source: Department of Finance and Administration Transparent Tennessee website: http://www.tn.gov,transparenttn,article,out-of-state-travel-reimbursed-expenses-2014

Appendix 7
Information Technology Procurement Process
Flow Chart



Appendix 8
Title VI and Other Information

According to the Tennessee Human Rights Commission's (THRC) 2013-2014 report, *Tennessee Title VI Compliance Program*, available on its website:

- the Department of Finance and Administration received $257,917,800 in federal dollars during the 2013-2014 period;
- the department filed a timely annual Title VI report (report filed on September 27, 2013, prior to due date of October 1, 2013;
- THRC did not receive any Title VI complaints against the department, and the department did not receive any complaints; and
- THRC did not issue any findings in the agency's annual Title VI report.

The department's job positions by title, gender and ethnicity follow.

Department of Finance and Administration
Staff Ethnicity and Gender
By Job Position
August 2015

Gender					Ethnicity					
Job Position	**Male**	**Female**	**Total**		**Asian**	**Black**	**Hispanic**	**White**	**Other**	**Total**
Account Clerk	0	1	1		0	0	0	1	0	1
Accountant 1	0	2	2		0	0	0	1	1	2
Accountant 2	9	8	17		1	2	0	13	1	17
Accountant 3	9	13	22		4	4	0	14	0	22
Accounting Administrator	0	2	2		0	0	0	2	0	2
Accounting Manager	3	15	18		0	3	0	14	1	18
Accounting Technician 1	4	8	12		0	4	0	8	0	12
Accounting Technician 2	7	23	30		1	3	0	24	2	30
Administrative Assistant 1	0	1	1		0	0	0	1	0	1
Administrative Assistant 2	0	1	1		0	1	0	0	0	1
Administrative Assistant 3	0	2	2		0	0	0	2	0	2
Administrative Secretary	0	1	1		0	0	0	0	1	1
Administrative Services Assistant 2	3	6	9		0	1	0	7	1	9

Gender					Ethnicity					
Job Position	**Male**	**Female**	**Total**		**Asian**	**Black**	**Hispanic**	**White**	**Other**	**Total**
Administrative Services Assistant 3	1	5	6		0	0	0	6	0	6
Administrative Services Assistant 4	3	10	13		0	0	1	12	0	13
Administrative Services Assistant 5	1	5	6		0	1	0	5	0	6
Architect - State	1	0	1		0	0	0	1	0	1
Architectural Compliance Director	0	1	1		0	0	0	1	0	1
Architectural Program Director	1	0	1		0	0	0	1	0	1
Assistant Commissioner 2	1	1	2		0	0	0	2	0	2
Attorney 3	1	2	3		0	1	0	2	0	3
Attorney 4	1	0	1		0	0	0	1	0	1
Audit Director 2	1	0	1		0	0	0	1	0	1
Auditor 2	0	2	2		0	1	0	1	0	2
Auditor 3	1	1	2		0	0	0	2	0	2
Auditor 4	1	1	2		1	0	0	1	0	2
Business Solutions Delivery Administrator	1	0	1		0	0	0	1	0	1
Budget Administrative Analyst 2	3	7	10		1	1	0	8	0	10
Budget Administrative Analyst 3	0	1	1		0	0	0	1	0	1
Budget Administrative Analyst 4	1	0	1		0	0	0	1	0	1
Budget Administrative Assistant Director	1	0	1		0	0	0	1	0	1
Budget Administrative Coordinator 1	2	2	4		0	0	0	4	0	4
Budget Administrative Coordinator 2	6	2	8		0	0	0	8	0	8
Budget Administrative Director	1	0	1		0	0	0	1	0	1

Gender					Ethnicity					
Job Position	**Male**	**Female**	**Total**		**Asian**	**Black**	**Hispanic**	**White**	**Other**	**Total**
Budget Analysis Director 1	1	0	1		0	1	0	0	0	1
Budget Process Transaction Director	2	0	2		0	0	0	2	0	2
Cabling Infrastructure Specialist 2	3	1	4		0	0	0	4	0	4
Cash Management Director	0	1	1		0	0	0	1	0	1
Chief of Accounts	1	1	2		0	0	0	2	0	2
Chief of Information Systems	1	0	1		0	0	0	1	0	1
Clerk 1	0	1	1		0	1	0	0	0	1
Commissioner 3	1	0	1		0	0	0	1	0	1
Communications Systems Analyst 4	2	0	2		0	0	0	2	0	2
Database Administrator 2	1	1	2		0	0	0	2	0	2
Database Administrator 4	4	1	5		1	0	0	4	0	5
Department Controller	3	2	5		0	0	0	5	0	5
Deputy Commissioner 2	1	0	1		0	0	0	1	0	1
End Point Technology Specialist	3	0	3		0	0	0	3	0	3
Epidemiologist	0	1	1		0	0	0	1	0	1
Enterprise Resource Planning Consultant 1	10	3	13		1	4	0	8	0	13
Enterprise Resource Planning Consultant 2	9	12	21		1	5	0	15	0	21
Enterprise Resource Planning Manager	3	2	5		0	1	0	4	0	5
Enterprise Resource Planning Module Lead	11	5	16		0	2	1	13	0	16

Gender					Ethnicity					
Job Position	**Male**	**Female**	**Total**		**Asian**	**Black**	**Hispanic**	**White**	**Other**	**Total**
Enterprise Resource Planning Module Lead-Senior	0	2	2		0	0	0	2	0	2
Enterprise Resource Planning Project Assistant Director	0	1	1		0	0	0	1	0	1
Enterprise Resource Planning Project Director	0	1	1		0	0	0	1	0	1
Executive Administrative Assistant 1	2	0	2		0	0	0	2	0	2
Executive Administrative Assistant 2	1	4	5		0	1	0	4	0	5
Executive Administrative Assistant 3	2	2	4		0	0	0	4	0	4
Finance and Administration Management Consultant 3	2	2	4		0	0	0	4	0	4
Finance and Administration Department Accounting Director	1	1	2		0	0	0	2	0	2
Finance and Administration Fiscal Director 1	3	2	5		0	0	0	5	0	5
Finance and Administration Fiscal Director 2	0	4	4		0	1	0	3	0	4
Finance and Administration Fiscal Director 3	0	2	2		0	0	0	2	0	2
Finance and Administration Program Director 1	8	4	12		0	0	0	11	1	12
Finance and Administration Program Director 2	1	6	7		0	1	0	6	0	7
Finance and Administration Program Director 3	0	2	2		0	0	0	2	0	2

Gender					Ethnicity					
Job Position	**Male**	**Female**	**Total**		**Asian**	**Black**	**Hispanic**	**White**	**Other**	**Total**
Fiscal Director 1	1	1	2		0	1	0	1	0	2
Funds Coordinator	3	2	5		1	1	0	3	0	5
General Counsel 2	0	1	1		0	0	0	1	0	1
Geographic Information Systems Analyst 2	4	0	4		0	0	0	4	0	4
Geographic Information Systems Analyst 3	2	1	3		0	0	0	3	0	3
Governor's Management Fellowship	1	4	5		0	0	0	5	0	5
Human Resources Analyst 2	0	3	3		0	0	0	3	0	3
Human Resources Manager 2	1	0	1		0	0	0	1	0	1
Information Resource Support Specialist 2	13	6	19		0	5	0	11	3	19
Information Resource Support Specialist 3	4	0	4		0	0	0	4	0	4
Information Resource Support Specialist 4	0	5	5		0	1	0	4	0	5
Information Resource Support Specialist 5	1	1	2		0	1	0	1	0	2
Information Officer	0	1	1		0	0	0	1	0	1
Information Systems Analyst 2	2	3	5		0	0	0	5	0	5
Information Systems Analyst 3	4	2	6		0	0	0	6	0	6
Information Systems Analyst 4	4	4	8		0	1	0	6	1	8
Information Systems Analyst Supervisor	1	1	2		0	0	0	2	0	2

Gender					Ethnicity					
Job Position	**Male**	**Female**	**Total**		**Asian**	**Black**	**Hispanic**	**White**	**Other**	**Total**
Information Systems Consultant	6	3	9		0	1	0	8	0	9
Information Systems Director 3	1	0	1		0	0	0	1	0	1
Information Systems Manager 1	0	1	1		0	1	0	0	0	1
Information Systems Manager 2	0	2	2		0	0	0	2	0	2
Information Systems Manager 3	2	1	3		0	1	0	2	0	3
Information Systems Manager 4	4	0	4		1	1	0	2	0	4
Information Systems Specialist 3	0	1	1		0	0	0	1	0	1
Information Systems Specialist 4	1	0	1		0	0	0	1	0	1
Information Systems Technology Consultant	62	35	97		3	6	1	86	1	97
Information Systems Technology Manager	4	1	5		0	2	0	3	0	5
Insurance Benefits Analyst 1	5	9	14		0	8	0	6	0	14
Insurance Benefits Analyst 2	3	5	8		0	5	0	3	0	8
Insurance Benefits Analyst 3	1	5	6		0	2	0	4	0	6
Insurance Benefits Manager	0	6	6		0	1	0	5	0	6
Insurance Benefits Specialist	5	14	19		1	3	0	15	0	19
Internal Service Fund Specialist	0	1	1		0	0	0	1	0	1
Information Technology Supervisor	0	1	1		0	1	0	0	0	1

Gender					Ethnicity					
Job Position	**Male**	**Female**	**Total**		**Asian**	**Black**	**Hispanic**	**White**	**Other**	**Total**
Legal Assistant	0	2	2		0	0	0	2	0	2
Mainframe Computer Technician 2	0	1	1		0	0	0	1	0	1
Office of Inspector General Case Review Specialist	2	1	3		0	0	1	2	0	3
Office of Inspector General Investigations Specialist Supervisor	0	1	1		0	0	0	1	0	1
Office of Inspector General Investigations Specialist	0	2	2		0	1	0	1	0	2
Office of Inspector General Nurse Consultant 2	0	5	5		0	1	0	4	0	5
Office of Inspector General Nurse Consultant Manager	0	1	1		0	0	0	1	0	1
Office of Inspector General Program Manager	0	1	1		0	0	0	1	0	1
Office of Inspector General Special Agent	11	2	13		0	1	0	12	0	13
Office of Inspector General Special Investigator	2	2	4		0	1	0	3	0	4
Office of Inspector General Director 1	2	0	2		0	0	0	2	0	2
Office of Inspector General Director 2	5	1	6		0	0	0	6	0	6

Gender					Ethnicity					
Job Position	**Male**	**Female**	**Total**		**Asian**	**Black**	**Hispanic**	**White**	**Other**	**Total**
Office of Inspector General Director 3	1	0	1		0	0	0	1	0	1
Planning Analyst 4	3	4	7		0	0	0	7	0	7
Planning Analyst 5	0	6	6		0	2	0	4	0	6
Procurement Officer 2	1	0	1		0	0	0	1	0	1
Program Monitor 2	0	1	1		0	0	0	1	0	1
Program Monitor 3	1	0	1		0	0	0	1	0	1
Programmer Analyst 2	1	0	1		0	0	0	1	0	1
Programmer Analyst 3	4	2	6		0	1	1	4	0	6
Programmer Analyst 4	12	5	17		1	2	0	12	2	17
Programmer Analyst Supervisor	0	1	1		0	0	0	1	0	1
Project Manager ASC	0	1	1		0	1	0	0	0	1
Project Manager INT	0	1	1		0	0	0	1	0	1
Regional Wellness Coordinator	0	3	3		0	1	0	2	0	3
Senior Project Manager	1	0	1		0	0	0	1	0	1
Systems Programmer 2	21	2	23		0	4	0	19	0	23
Systems Programmer 3	31	1	32		0	2	0	28	2	32
Systems Programmer 4	53	4	57		1	8	0	48	0	57
Talent Management Director 3	1	0	1		0	0	0	1	0	1
TennCare Assistant Inspector General	2	0	2		0	0	0	2	0	2
TennCare Inspector General	1	0	1		0	0	0	1	0	1
Tennessee Information Billing System Consultant 2	1	0	1		0	0	0	1	0	1

Gender					Ethnicity					
Job Position	**Male**	**Female**	**Total**		**Asian**	**Black**	**Hispanic**	**White**	**Other**	**Total**
Tennessee Information Billing System Consultant 3	0	3	3		0	0	0	3	0	3
Tennessee Information Billing System Consultant Manager	1	0	1		0	0	0	1	0	1
Tennessee Information Billing System Consultant Supervisor	0	2	2		0	0	0	2	0	2
Workstation Specialist - ADV	9	0	9		0	1	0	8	0	9
Workstation Specialist - INT	11	2	13		0	4	0	8	1	13
	451	**366**	**817**		**19**	**111**	**5**	**664**	**18**	**817**

Appendix 9
Performance Measures Information

As stated in the Tennessee Governmental Accountability Act, "accountability in program performance is vital to effective and efficient delivery of government services, and to maintain public confidence and trust in government." In accordance with this act, all executive branch state agencies are required to submit annually to the Department of Finance and Administration a strategic plan and program performance measures. The Department of Finance and Administration's priority goals, for fiscal year 2015, as reported on the Governor's Customer Focused Government Monthly Results website, are as follows:

Priority Goals and Measures

Priority Goal 1: Move forward with NextGen IT through a successful pilot at TDOT and the conversion of two other departments by 6/30/2015.
Purpose of the Goal: Position agencies to improve their IT project implementations by modernizing the IT organization to reflect the 21st century needs of the agency. Provide relevant training to state IT staff. Final phase encompasses agencies creating new IT organizational structures as outlined in SAIC assessments and hiring staff into newly created IT classifications. TDOT is underway as a pilot implementation. F&A and TDFI will implement, all to be completed and assessed (including financial impact) by June 30, 2015.
Measuring the Goal:

	Baseline	Current	Target
Number of agencies completing reorganization of IT Departments based on SAIC assessments	0	1	2

Priority Goal 2: Implement year three of the centralized accounting plan.
Purpose of the Goal: Centralized accounting will enhance the ability to consistently maintain and close the accounting records to prepare timely interim and annual financial reports. State management will benefit from decision-useful timely financial reporting. External customers, such as bondholders and municipal analysts will also benefit from timely financial reporting.
Measuring the Goal:

	Baseline	Current	Target
Number of agencies with accounting centralized	0	3.1	4

Priority Goal 3: Implement year one of the workstation consolidation plan.
Purpose of the Goal: Improved processes for securing, updating and managing workstations resulting in a reduction of workstation security issues. Development of standard images and base platforms. Centralized Service Desk will realize economies of scale for ticket receipt and processing. Centralized patch and software management.
Measuring the Goal:

	Baseline	Current	Target
Number of agencies migrated	1	10	9